OKLAHOMA POLICE PENSION AND RETIREMENT SYSTEM
1001 N.W. 63rd Street, Suite 305
Oklahoma City, OK 73116 7335
Tel: (405) 840-3555 or (800) 347-6552 Fax: (405) 840-8465
www.opprs.ok.gov

AUTHORIZATION TO RELEASE MEDICAL, PSYCHIATRIC AND PSYCHOLOGICAL INFORMATION

Patient's Name _____

Date of Birth _____

Social Security Number _____

TO WHOM IT MAY CONCERN:

I hereby request and authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf to furnish to the Oklahoma Police Pension and Retirement System and/or the Retirement Board and any representative thereof (collectively, the "System") any and all records, information and evidence in their possession regarding my injuries, medical history, physical condition, and psychiatric/psychological information, including information related to alcohol or drug abuse, both prior and subsequent to the date below until this authorization expires or until I revoke this authorization. Any or all of such health information is referred to in this authorization as my "protected health information" or "PHI."

Upon presentation of this authorization, or an exact photocopy thereof, you are directed (1) to permit the personal review, copying or photostatting of such records, information and evidence by the System or (2) to provide copies of such records to the System.

I further understand that, if my PHI is transmitted or maintained electronically (my "electronic PHI"), you or any agent or subcontractor that creates, receives, maintains, or transmits my electronic PHI will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of my electronic PHI, and you will ensure that any agent (including a subcontractor) to whom you provide my electronic PHI agrees to implement reasonable and appropriate security measures to protect my PHI.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.

I hereby acknowledge that the information authorized for release may include information which may be considered information about a communicable or venereal disease, which may include, but is not limited to, a disease such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

I also acknowledge that the information that is used or disclosed pursuant to this authorization may be used or redisclosed by the System for purposes of eligibility and benefits determinations and, if presented at a Retirement Board meeting and/or hearing, the information may become part of a public record.

I understand that I may revoke this authorization at any time, in writing, except that revocation will not apply to information already used or disclosed in response to this authorization.

Unless revoked or otherwise indicated, this authorization will expire two years from date of signature.

I hereby release the System from any liability in connection with the release of information pursuant to this authorization.

Signature _____ Date _____