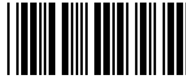

NYCERS USE ONLY

F608

General Authorization for Medical Information

This form authorizes NYCERS to obtain medical information pertaining to those filing for disability. NYCERS understands that information about your health is personal and we are committed to protecting your privacy. Please be sure you understand how NYCERS will use your medical information prior to signing this form. Should you have any questions, please contact our Call Center at 347-643-3000.

Member Number	Last 4 Digits of SSN	Date of Birth [MM/DD/YYYY]
		/ /

First Name	M.I.	Last Name

Address	Apt. Number

City	State	Zip Code

Name of Hospital or Medical Group

Dates of treatment/service: [MM/DD/YYYY] / / [MM/DD/YYYY] / / [MM/DD/YYYY] / / [MM/DD/YYYY] / /

Expiration date of this authorization: [MM/DD/YYYY] / /

Please initial each of the following to state your understanding of this form.

☐ I understand that by completing this form in full, I authorize the use and disclosure of my medical records for the purpose of applying for disability retirement.

☐ I understand that this information may be re-disclosed if the recipient(s) described on this form is not required by applicable law to protect the privacy of the information and such information is no longer protected by federal health information privacy regulations.

☐ I understand that my medical records may contain information relating to Alcohol or Drug Abuse, genetic testing, psychiatric care and/or confidential HIV/AIDS related information.

☐ I understand that if I am authorizing the use or disclosure of HIV/AIDS related information, the recipient is prohibited from using or redisclosing any HIV/AIDS related information without my authorization unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS related information, I may contact New York State Division of Human Rights at 212-480-2493 or the New York City Commission of Human Rights at 212-306-7450. These agencies are responsible for protecting my rights.

☐ I have read this form and all of my questions about this form have been answered. By signing below I acknowledge that I have read and accept all of the above and hereby authorize any hospital, medical group, or other organization to disclose all information to the New York City Employees' Retirement System.

Signature of Member	**Date**