



**AUTHORIZATION FOR RELEASE
OF HEALTH-RELATED INFORMATION**



TEACHERS' RETIREMENT SYSTEM
OF THE CITY OF NEW YORK (TRS)
55 Water Street, New York, NY 10041
www.trsnyc.org • 1 (888) 8-NYC-TRS

This form authorizes release of medical information, including HIV-related information, to the Teachers' Retirement System of the City of New York (TRS) pertaining to filing for disability benefits. This authorization complies with the U.S. Department of Health and Human Services Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The information you provide may be protected from disclosure by federal and state privacy laws.

By initialing on page 2 where indicated and signing this form, you agree that medical information and/or HIV-related information may be provided to TRS and the TRS Medical Board and Medical Review Panel for the purpose of determining your eligibility for disability benefits.





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PART A: PERSONAL INFORMATION Please provide the information below.

First Name	MI	Last Name	Social Security Number (last 4 digits only)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> - <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Permanent Home Address	Apt. No.		TRS Membership/Retirement Number
<input type="text"/>	<input type="text"/>		<input type="text"/>
City	State	Zip Code	Primary Phone Number (Check one: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile)
<input type="text"/>	<input type="text"/>	<input type="text"/>	(<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Email Address			Alternate Phone Number (Check one: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile)
<input type="text"/>			(<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Check here if you entered new contact information above. TRS will then update our records based on what you entered.

Please keep your contact information up to date. You can visit our website to update your contact information anytime, or file a "Member's Change of Address Form" (code DM13) with TRS.

PART B: Please write your initials in the space provided to confirm your understanding of each statement.

_____ *I understand that TRS may re-direct the information described on this form on proper request if TRS is not required by applicable law to protect the privacy of this information and such information is no longer protected by federal health information privacy regulations.*

_____ *I understand that my medical records may contain information related 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 re-disclosing any HIV/AIDS-related information without my authorization unless permitted to do so under federal or state law. I also understand that I have the 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 the New York State Division of Human Rights at 1 (888) 392-3644 or the New York City Commission on 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 my medical information to the Teachers' Retirement System of the City of New York (TRS).*

MEMBER'S SIGNATURE _____ DATE: (MM/DD/YYYY) _____

