SCHOOL EMPLOYEES RETIREMENT SYSTEM OF OHIO
300 E. BROAD ST., SUITE 100 • COLUMBUS, OHIO 43215-3746
614-222-5853 • Toll-Free 800-878-5853 • www.ohsers.org

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

______________________________ ☐☐☐-☐☐-☐☐☐☐
Applicant's Name (please print) Social Security Number

____
Applicant's Address

______________________________ ______________________________
Date of Birth Phone Number

In connection with my application for disability benefits, I, the undersigned, authorize the following health care provider to release my individually identifiable health information to School Employees Retirement System of Ohio. This authorization includes release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions.

____
Name of Treating Physician/Health Care Provider Specialty

____
Street Address Fax Number

____
City, State, Zip Phone Number

Check the type of information that you want to be used or disclosed pursuant to this Authorization:

☐ All medical records; or ☐ only medical records described below are to be disclosed:

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In addition, I further authorize the medical records to be released contain the following dates of treatment:

☐ All dates of treatment; or ☐ only records for the following dates are to be disclosed:

____

____

This statement must be signed and dated and may be revoked at any time except to the extent action has been taken prior to revocation. This consent will expire one year after the date below, or sooner by my choice, in which case this consent will expire on _______________ .

I hereby consent to the disclosure of the treatment records to the purpose and extent stated above. Further, I understand I am responsible for any fees associated with the release of these records.

Signature ______________________________ **Date** ____________________