SERS
State Employees' Retirement System
srs.illinois.gov

2101 South Veterans Parkway
P.O. Box 19255
Springfield, IL 62794-9255

217-785-7444
Fax 217-785-6961
Email: sers@srs.illinois.gov

Release of Information Authorization

I authorize any licensed medical professional, hospital, insurer, the Social Security Administration or another organization have any records, data or information concerning me to furnish such records, data or information to the State Employees' Retirement System of Illinois (SERS).

The type of information to be disclosed includes the patient's entire medical record, employment record (including salary postings) or a record of all benefit payments.

I understand that the information being disclosed may include information relating to sexually transmitted disease, acquire immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse and generic health information from medical records.

The information for which I am authorizing disclosure will be used for establishing eligibility for disability benefits from SERS.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

This authorization will expire 12 months from the date of signature listed below, unless otherwise revoked.

I understand that once the above information is received, it may be disclosed by the recipient pursuant to evaluating my continued eligibility for disability benefits, and may no longer be protected by federal privacy regulations. SERS is not liable for any consequences of such redisclosure.

I understand that authorizing the use or disclosure of the information identified is mandatory to establish my eligibility for disability benefits.

Name _____

Address *(Street)* _____

(City, State, Zip) _____

Email address _____

Phone number
(H) _____
(W) _____
(C) _____

SSN *(last 4)* **or Member ID** _____

Date of birth _____

By signing below, I certify this information is correct and that I am aware that knowingly making a false statement or falsifying a record in an attempt to defraud SERS is a class 3 felony. I understand that if the SERS Board of Trustees has a reasonable suspicion that an attempt has been made to defraud SERS, it is required to report the matter to the appropriate State's Attorney for investigation.

Signature _____ **Date** _____

Witness* _____ **Date** _____

**Must be age 18 or older.*