Reset Form

TENNESSEE CONSOLIDATED RETIREMENT SYSTEM
502 Deaderick Street
Nashville, Tennessee 37243-0201
(615) 741-1971

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize the following healthcare provider(s) and its physicians, employees and agents to release or disclose to the Tennessee Consolidated Retirement System (TCRS) and its representatives all of my medical records including records pertaining to treatment, prognosis and diagnosis, including any specially protected or listed records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection. (Please list at least one healthcare provider. If you have more than three, please list them on another form.)

Healthcare Provider	Address	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I further authorize you to provide to and discuss with TCRS and its representatives any confidential information with respect to my medical condition or treatment, either formally or informally.

Release Records To: Tennessee Consolidated Retirement System and representatives thereof
502 Deaderick Street
Nashville, Tennessee 37243-0201

Patient's Name: _____ **SSN:** _____ **Date of Birth:** _____

Which Records?: All medical, psychiatric, psychological diagnosis and treatment records, hospital records, and any records pertaining to my medical history, pathology, including tissue samples, slides and/or blocks, charts and x-ray film reports

Purpose of Disclosure: For use in pending application for disability retirement benefits

I understand that I may revoke the Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by the above-named healthcare provider(s) or its physicians, employees or agents before the healthcare provider(s) received my revocation. Should I desire to revoke this Authorization, I must send written notice to the healthcare provider(s).

I understand that I am not required to sign this Authorization. The above-named healthcare provider(s) will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization. However, I further understand that if I do not sign this authorization, I may not be eligible to obtain disability retirement benefits from TCRS since TCRS must have competent medical records to document that I am totally and permanently disabled from all substantial gainful employment.

I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit the above-named healthcare provider(s) or its physicians', employees' or agents' ability to use or disclose my information for treatment, payment, or healthcare operations, or as otherwise permitted by law.

I further understand and acknowledge that I am responsible for all costs associated with the provision of the information described herein to the TCRS.

Patient or Authorized Representative's Signature: _____

Relationship to Patient: _____ **Date:** _____

THIS AUTHORIZATION WILL EXPIRE TWO YEARS AFTER THE DATE OF SIGNATURE ABOVE.
A PHOTOSTATIC COPY OF THIS AUTHORIZATION IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.