MCERA

Disability Retirement Application Forms

Inside this packet:

- Application for Disability Retirement Checklist
- Instructions for Completing the MCERA Disability Retirement Application
- MCERA Disability Retirement Application Form
- Statement of Representation Form
- Authorization Forms for Release of Medical, Psychiatric and Employment Information

Introduction

This document contains the Disability Retirement Application as well as all other required forms. You can use the checklist on the following page as a guide to ensure that you return a complete disability retirement application packet to MCERA. Instructions for completing the Disability Retirement Application are also included.

Disability Retirement Counseling

You may contact MCERA to schedule a disability retirement counseling appointment either before or after you file your Disability Retirement Application. The Disability Coordinator will review the following topics with you:

- Eligibility requirements for service connected disability retirement, non-service connected disability retirement, and service retirement.
- Supporting documentation needed to process the disability application.
- Effective date of benefits.
- Timeline and applicant's role.
- Reciprocity.
- Safety member presumption requirements.
- Legal representation.
- Health, dental, and vision coverage, before and after the disability application process.
- Current beneficiary designation and death benefits.

Additional Resources

If you have questions as you complete the forms, the following resources are available:

- **Disability Retirement Handbook**
  The handbook is available online at MCERA.org or upon request.

- **MCERA Staff**
  If you have questions about disability retirement, please contact:

  Linda Martinez
  MCERA Disability Coordinator
  (415) 473-6153
  LMartinez@marincounty.org

  If you have questions about service retirement benefits, please contact:

  MCERA Active Member Benefits
  (415) 473-4148
  MCERABenefits@marincounty.org

Application for Disability Retirement

Checklist

In order for MCERA to accept and deem your application for disability retirement complete, you must submit one original and three copies of all of the following required documents.

- ☐ **Disability Retirement Application.** The form can be completed electronically or by hand with clear printing and dark ink, and must be submitted in hard copy with an original signature. Instructions for completing the Disability Retirement Application are included in this packet.

- ☐ **Statement of Legal Representation** (if represented)**.** This form must be signed by your attorney. A letter of representation from your attorney may be substituted in place of this form.

- ☐ **Physician Statement.** A statement from your treating physician that includes written diagnosis of your injury or illness, the prognosis that your disability is permanent, and the causation (if applicable) that must be on your physician's stationery.

- ☐ **Job Description.** As noted in Section 6 of the Disability Retirement Application, you must include a copy of the job description for the position you held at the time of the injury/illness.

- ☐ **MCERA Authorization for Release of Medical, Psychiatric and Employment Records and Information.** Section 1 of this form can be completed electronically or by hand with clear printing and dark ink.

- ☐ **Kaiser Permanente Authorization for Use and/or Disclosure of Member/Patient Health Information.** This form can be completed electronically or by hand with clear printing and dark ink. You may only omit this form only if you have never been treated at a Kaiser facility or by a Kaiser physician.

- ☐ **UCSF Medical Center Authorization for Release of Health Information.** This form can be completed electronically or by hand with clear printing and dark ink. You may omit this form only if you have never been treated at a UCSF facility or by a UCSF physician.

- ☐ **All Supporting Medical Records and Reports.** It is your responsibility to provide MCERA with any documentation that will support your claim. The documentation must prove that you are permanently disabled from substantially performing your usual and customary job duties. For a service connected disability retirement, the documentation must also demonstrate that there was a "real and measurable" connection between your employment and the disability. Supporting documentation may also include copies of x-rays, MRI, CT scans, or any other tests or films, preferably on CD.

Instructions

for Completing the Disability Retirement Application

Section 1

Application Type

Indicate whether you are applying for service connected or non-service connected disability retirement. You must have at least five years of credited service to be eligible for a non-service connected disability retirement.

Section 2

Applicant Information

Please fill out this section thoroughly, including your contact information and Social Security number. This enables us to communicate with you regarding your application. If you change your address and/or phone number, please inform us of your new information immediately.

Section 3

Current Employment Information

Provide the information requested about your current or most recent MCERA-covered employer, including accurate information regarding your pay status if you are still employed. This information is important because it will assist MCERA in determining the effective date of your disability retirement if your application is granted.

Section 4

Attorney Information

You are entitled to legal representation at your own expense but you are not required to have an attorney. If you are represented by legal counsel please complete the information in this section as well as the Statement of Legal Representation form. Your legal counsel will then be MCERA's contact throughout this process.

Section 5

Description and Onset of Subject Injury/Illness

Tell us about your disability. The more complete this information is, the better the Medical Advisor can make a recommendation on your disability status. If there was a delay between your filing of the application and your last day of regular compensation from an MCERA-covered employer, please explain why. If you have more than one illness/injury, you may provide the information and file the application for both conditions. However, you must provide independent supporting documentation for each. You may not add an additional illness or injury to your application later, but instead would need to file a new, separate, application.

Section 6

Job Description and Essential Functions

Attach a copy of the job description for the position you held at the time of the injury/illness and indicate whether the job description is accurate. List the usual and customary duties of your position and state in detail the duties you cannot now perform due to your injury/illness.

Section 7

Workers' Compensation Relating to Subject Injury/Illness

Provide information on any Workers' Compensation claims you have filed relating to the injury/illness.

Section 8

Physician Information Relating to Subject Injury/Illness

Provide complete contact information for physicians and healthcare providers you have consulted for diagnosis or treatment of your injury/illness, including the reason for your visit, and dates of treatment. Also include information for appointments scheduled in the future.

Section 9

Information Relating to Similar Injury/Illness

Indicate whether you have been treated for a similar injury/illness and, if so, provide complete contact information for your treating physicians and healthcare providers including the dates of treatment and whether a Workers' Compensation claim was filed.

Section 10

Other Current and Prior Employment Information

Provide all information regarding current employment in **Section 10B** so that we may contact you regarding your current duties, if you are working for another employer.

In **Section 10C** complete the information for all prior employers for whom you have worked in the last ten years.

Section 11

Information Relating to Third Party

Complete this section if it is possible that your injury/illness was caused or related to any injury, problem or incident involving a third party other than your most recent MCERA-covered employer. If there is no third party involvement check "no" in **Section 11A.**

Section 12

Additional Information Supporting Disability Application

You may include any additional information that might help the Board of Retirement decide your case.

Section 13 Physician Information Relating to All Other Health Matters

Provide the complete contact information, including dates of treatment and reasons for visit, for all physicians and healthcare providers consulted for any other reason during the five years preceding the onset of the injury/illness indicated in **Section 5** of this application.

Section 14 Applicant Signature

By signing the application you affirm that the information provided in the application and the supporting documentation provided is true and correct. Your application must be signed prior to submission or it will be returned to you.

mcera

Marin County Employees' Retirement Association
One McInnis Parkway, Suite 100, San Rafael, CA 94903-2764
Main: (415) 473-6147 • Fax: (415) 473-4179 • Web: www.mcera.org

DISABILITY RETIREMENT APPLICATION

(PLEASE PRINT OR TYPE)

SECTION 1: APPLICATION TYPE

I have become permanently incapacitated from the performance of my duties and, accordingly, I hereby apply for:

☐ Service connected disability retirement ☐ Non-service connected disability retirement

SECTION 2: APPLICANT INFORMATION

LAST NAME	FIRST NAME		SOCIAL SECURITY NUMBER	
MAILING ADDRESS			BIRTHDATE	AGE
CITY	STATE/COUNTRY	ZIP CODE	GENDER ☐ Male ☐ Female	
HOME PHONE	CELL PHONE		WORK PHONE	
EMAIL ADDRESS				

MARITAL STATUS

Check all that apply: ☐ Married ☐ Divorced ☐ Divorced after membership entry ☐ Single ☐ Widowed

► *Please provide a copy of government-issued proof of birth (birth certificate, passport, etc.) and marriage certificate/state registered partnership certificate for the person identified below.*

SPOUSE LAST NAME	SPOUSE FIRST NAME	SPOUSE SOCIAL SECURITY NUMBER

SECTION 3: CURRENT EMPLOYMENT INFORMATION

EMPLOYER	DEPARTMENT	DATE LAST WORKED
LAST POSITION HELD	SUPERVISOR	YEARS OF SERVICE

CURRENT EMPLOYMENT STATUS (CHECK ALL THAT APPLY)

☐ Working _____ hours per week
☐ Sick leave with compensation
☐ Sick leave without compensation
☐ Other (please specify):
☐ Receiving 4850 time
☐ Resigned or terminated from service
☐ Working modified schedule or with accommodation
☐ Retired on (date): _____

SECTION 4: ATTORNEY INFORMATION

Are you, or will you be, represented in this application for disability retirement by an attorney?

☐ Yes ☐ No

If you answered "Yes" please complete the information below and the Statement of Legal Representation form in this packet, or submit a Letter of Representation from your attorney.

ATTORNEY NAME	LAW FIRM NAME

LAST NAME

SECTION 5: DESCRIPTION AND ONSET OF SUBJECT INJURY/ILLNESS

5A Describe specifically the injury or illness that you claim is causing you to be <u>permanently</u> disabled from performing your duties.

5B How and where did the injury or illness occur? Please answer completely.

5C On what date were you injured, or first noticed that you were ill? _____

5D If your disability is the result of a job-related injury, list all of the witnesses who observed the injury. Give names, work locations, telephone numbers and addresses of such persons and state your relationship to each. Please use an additional sheet if necessary.

WITNESS 1		
WITNESS' NAME	WITNESS' WORK LOCATION	WITNESS' STREET ADDRESS
RELATIONSHIP TO APPLICANT	WITNESS' PHONE NUMBER	WITNESS' CITY/STATE/ZIP
WITNESS 2		
WITNESS' NAME	WITNESS' WORK LOCATION	WITNESS' STREET ADDRESS
RELATIONSHIP TO APPLICANT	WITNESS' PHONE NUMBER	WITNESS' CITY/STATE/ZIP
WITNESS 3		
WITNESS' NAME	WITNESS' WORK LOCATION	WITNESS' STREET ADDRESS
RELATIONSHIP TO APPLICANT	WITNESS' PHONE NUMBER	WITNESS' CITY/STATE/ZIP
WITNESS 4		
WITNESS' NAME	WITNESS' WORK LOCATION	WITNESS' STREET ADDRESS
RELATIONSHIP TO APPLICANT	WITNESS' PHONE NUMBER	WITNESS' CITY/STATE/ZIP

LAST NAME

SECTION 6: JOB DESCRIPTION AND ESSENTIAL FUNCTIONS

Please attach a copy of the job description for the position that you currently hold. County of Marin employee job descriptions are available on the County's Human Resources website. If you need assistance please contact the MCERA Disability Coordinator.

Please answer the following questions.

6A Is the job description accurate? ☐ Yes ☐ No

6B If you answered "No" to question 6A, please list the duties you performed which you feel are omitted from the description. Also, list those duties included in the description which you did not perform on a regular and routine basis.

6C Please list the usual and customary duties of your position and whether you are able to perform them.

_____ ☐ Yes ☐ No

_____ ☐ Yes ☐ No

_____ ☐ Yes ☐ No

_____ ☐ Yes ☐ No

6D State in detail the duties you cannot now perform due to your injury or illness.

SECTION 7: WORKERS' COMPENSATION RELATING TO SUBJECT INJURY/ILLNESS

7A Have you filed a Workers' Compensation claim relating to the injury or disease for which this disability retirement application is filed?

☐ Yes ☐ No

7B If you answered "Yes" to question 7A, please complete the following.

Claim Number: _____ Date Claim Submitted: _____

Status of Claim: ☐ Pending ☐ Approved ☐ Denied

7C If you answered "No" to question 7A, please explain why a claim was not submitted.

LAST NAME

SECTION 8: PHYSICIAN INFORMATION RELATING TO SUBJECT INJURY/ILLNESS

List the names, addresses and telephone numbers of all physicians and health care providers consulted for diagnosis or treatment relating to the injury or illness for which this disability retirement application is filed. Include approximate dates of consultation, if known. Please include all physicians or health care providers with whom you have appointments scheduled for additional medical services in the future that pertain to this injury or illness. Please attach a separate sheet if necessary.

MEDICAL PROVIDER 1		
PROVIDER NAME	STREET ADDRESS	REASON FOR VISIT
PHONE NUMBER	CITY/STATE/ZIP	DATES OF TREATMENT
MEDICAL PROVIDER 2		
PROVIDER NAME	STREET ADDRESS	REASON FOR VISIT
PHONE NUMBER	CITY/STATE/ZIP	DATES OF TREATMENT
MEDICAL PROVIDER 3		
PROVIDER NAME	STREET ADDRESS	REASON FOR VISIT
PHONE NUMBER	CITY/STATE/ZIP	DATES OF TREATMENT
MEDICAL PROVIDER 4		
PROVIDER NAME	STREET ADDRESS	REASON FOR VISIT
PHONE NUMBER	CITY/STATE/ZIP	DATES OF TREATMENT

SECTION 9: INFORMATION RELATING TO SIMILAR INJURY/ILLNESS

9A Have you ever received treatment for a similar injury or illness? ☐ Yes ☐ No

9B If you answered "Yes" to question 9A, please provide the names, addresses, telephone numbers and dates of treatment for all physicians or health care providers. Indicate if the consultation resulted in a Workers' Compensation claim being filed.

MEDICAL PROVIDER 1		
MEDICAL PROVIDER NAME	STREET ADDRESS	DATES OF TREATMENT
PHONE NUMBER	CITY/STATE/ZIP	WORKERS COMPENSATION CLAIM ☐ Filed ☐ Not filed
MEDICAL PROVIDER 2		
MEDICAL PROVIDER NAME	STREET ADDRESS	DATES OF TREATMENT
PHONE NUMBER	CITY/STATE/ZIP	WORKERS COMPENSATION CLAIM ☐ Filed ☐ Not filed
MEDICAL PROVIDER 3		
MEDICAL PROVIDER NAME	STREET ADDRESS	DATES OF TREATMENT
PHONE NUMBER	CITY/STATE/ZIP	WORKERS COMPENSATION CLAIM ☐ Filed ☐ Not filed

LAST NAME

SECTION 10: OTHER CURRENT AND PRIOR EMPLOYMENT INFORMATION

10A Are you presently employed, full-time, part-time, or otherwise, or do you do volunteer work for anyone other than the employer under which you incurred the injury or illness for which this disability retirement application is filed?

☐ Yes ☐ No

10B If you answered "Yes" to question 10A, please list the employer or volunteer organization, address, telephone number and your job duties.

CURRENT EMPLOYER/VOLUNTEER ORGANIZATION 1

EMPLOYER NAME	STREET ADDRESS	PHONE NUMBER
SUPERVISOR	CITY/STATE/ZIP	☐ Full-time ☐ Part-time ☐ Other: _____
JOB DUTIES		

CURRENT EMPLOYER/VOLUNTEER ORGANIZATION 2

EMPLOYER NAME	STREET ADDRESS	PHONE NUMBER
SUPERVISOR	CITY/STATE/ZIP	☐ Full-time ☐ Part-time ☐ Other: _____
JOB DUTIES		

CURRENT EMPLOYER/VOLUNTEER ORGANIZATION 3

EMPLOYER NAME	STREET ADDRESS	PHONE NUMBER
SUPERVISOR	CITY/STATE/ZIP	☐ Full-time ☐ Part-time ☐ Other: _____
JOB DUTIES		

10C Please list all prior employers (including other County or City departments or agencies), dates of employment, and name of supervisor for whom you have worked in the last ten (10) years. Please attach a separate sheet if necessary.

PRIOR EMPLOYER 1

EMPLOYER NAME/DEPARTMENT	STREET ADDRESS	SUPERVISOR PHONE NUMBER
SUPERVISOR	CITY/STATE/ZIP	DATES OF EMPLOYMENT

PRIOR EMPLOYER 2

EMPLOYER NAME/DEPARTMENT	STREET ADDRESS	SUPERVISOR PHONE NUMBER
SUPERVISOR	CITY/STATE/ZIP	DATES OF EMPLOYMENT

PRIOR EMPLOYER 3

EMPLOYER NAME/DEPARTMENT	STREET ADDRESS	SUPERVISOR PHONE NUMBER
SUPERVISOR	CITY/STATE/ZIP	DATES OF EMPLOYMENT

LAST NAME

SECTION 11: INFORMATION RELATING TO THIRD PARTY (AS APPLICABLE)

11A Is it possible that your injury or illness was caused or related, in whole or in part, to any injury, problems or incident involving any third party, other than your most recent employer?

☐ Yes ☐ No

11B Have you filed, or are you considering filing, any claim or lawsuit against any third party or its insurance company for any injury, disability, or loss of past or future income or earning capacity?

☐ Yes ☐ No

11C If applicable, include the name, address and telephone number of the third party(ies) and/or insurance company(ies). Please attach a separate sheet if necessary.

THIRD PARTY 1

PARTY NAME	STREET ADDRESS
PHONE NUMBER	CITY/STATE/ZIP

THIRD PARTY 2

PARTY NAME	STREET ADDRESS
PHONE NUMBER	CITY/STATE/ZIP

11D If applicable, what is the status of your claim or lawsuit against the third party(ies)?

11E Are you, or will you be, represented by an attorney in connection with your claim or lawsuit against the third party?

☐ Yes ☐ No

If you answered "Yes" please provide the information for your attorney, below.

ATTORNEY NAME	LAW FIRM		WORK PHONE
ATTORNEY ADDRESS			CELL PHONE
CITY	STATE/COUNTRY	ZIP CODE	EMAIL ADDRESS

SECTION 12: ADDITIONAL INFORMATION SUPPORTING DISABILITY APPLICATION

Include any further information you can offer to help the Board of Retirement in determining whether or not you meet the criteria for a disability retirement. Attach additional pages as necessary.

LAST NAME

SECTION 13: PHYSICIAN INFORMATION RELATING TO ALL OTHER HEALTH MATTERS

List the names, addresses and telephone numbers of all physicians and health care providers consulted for any other reason during the five (5) years preceding he onset of the injury or illness for which this disability retirement application is filed. Include approximate dates of consultation, if known. Please attach a separate sheet if necessary.

MEDICAL PROVIDER 1		
PROVIDER NAME	STREET ADDRESS	REASON FOR VISIT
PHONE NUMBER	CITY/STATE/ZIP	DATES OF TREATMENT
MEDICAL PROVIDER 2		
PROVIDER NAME	STREET ADDRESS	REASON FOR VISIT
PHONE NUMBER	CITY/STATE/ZIP	DATES OF TREATMENT
MEDICAL PROVIDER 3		
PROVIDER NAME	STREET ADDRESS	REASON FOR VISIT
PHONE NUMBER	CITY/STATE/ZIP	DATES OF TREATMENT
MEDICAL PROVIDER 4		
PROVIDER NAME	STREET ADDRESS	REASON FOR VISIT
PHONE NUMBER	CITY/STATE/ZIP	DATES OF TREATMENT

SECTION 14: APPLICANT SIGNATURE

PLEASE NOTE:

This application does not replace any medical and/or other documentation which you may wish to submit in support of your application. It is the responsibility of the applicant to submit all supporting evidential data including, but not limited to, copies of x-rays, MRI, CT scans, or any other tests or films, preferably on CD. Failure to submit all tests and records will delay consideration of your application.

You must provide the original plus three (3) copies of the application and all supporting documentation you wish to submit.

I hereby authorize MCERA to obtain my medical records, to contact the attorney identified in this application, or any attorney that I may appoint in the future, to discuss my application and my medical records. I have included the general medical release and Kaiser release forms with my application.

I declare under penalty of perjury that the foregoing is true and correct.

APPLICANT SIGNATURE	DATE
AUTHORIZED EMPLOYER SIGNATURE *	DATE *

** Required only when employer files on behalf of the employee.*

mcera

Marin County Employees' Retirement Association
One McInnis Parkway, Suite 100, San Rafael, CA 94903-2764
Main: (415) 473-6147 • Fax: (415) 473-4179 • Web: www.mcera.org

STATEMENT OF LEGAL REPRESENTATION

SECTION 1: APPLICANT INFORMATION

LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER
STREET ADDRESS		CITY/STATE/ZIP

SECTION 2: AUTHORIZATION

This is to advise that I have retained the firm stated below in Section 3 as my Attorney(s) and legal representative(s) for the purposes of prosecuting my Application for Service Connected/Non-Service Connected Disability Retirement Benefits filed with the Marin County Employees' Retirement Association (MCERA).

The scope of representation by the above-mentioned Attorney(s)/Firm is limited as follows:

_____

_____

_____

_____

_____

☐ Please check here if there are no limitations

SECTION 3: LEGAL REPRESENTATIVE INFORMATION

ATTORNEY NAME	LAW FIRM NAME
STREET ADDRESS	
CITY, STATE, ZIP	PHONE
EMAIL	
ATTORNEY SIGNATURE	DATE

AUTHORIZATION FOR RELEASE OF MEDICAL, PSYCHIATRIC AND EMPLOYMENT RECORDS AND INFORMATION

Marin County Employees' Retirement Association
One McInnis Parkway, Suite 100, San Rafael, CA 94903-2764
Main: (415) 473-6147 • Fax: (415) 473-4179 • Web: www.mcera.org

SECTION 1: APPLICANT INFORMATION

LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER

STREET ADDRESS	CITY/STATE/ZIP

SECTION 2: AUTHORIZATION

I, the undersigned, hereby authorize any and all physicians, hospitals, medical groups and other providers of health service and Tristar Risk Management and/or any other Workers' Compensation insurer or adjuster, to release to the Marin County Employees' Retirement Association (MCERA) any and all medical, psychiatric and psychological records, reports, or other writings relative to my past and present medical and/or psychological condition. I authorize the release of all medical, psychological and psychiatric records notwithstanding and with a waiver of California Assembly Bill 435, Civil Code §56 *et seq.*, and Labor Code §3751 and §3762 *et seq.*

The medical information disclosed pursuant to this authorization may be provided to the staff, Board and attorneys of the MCERA for use in connection with processing, adjudication and determination of my application for a disability retirement.

I hereby authorize my past, present and future employers to release to MCERA any and all documentation contained in the undersigned's Personnel File maintained by the Human Resources Department, any other Department of the undersigned's Employer and/or any file maintained by the undersigned's Supervisor(s).

This authorization shall remain effective during the pendency of my application for a disability retirement or two (2) years after the date this release is signed by me, whichever is earlier. I have been advised by this sentence that I have a right to a copy of this authorization. A photocopy of this signed authorization shall be as valid as the original.

APPLICANT SIGNATURE	DATE

KAISER PERMANENTE®

Kaiser Foundation Hospitals
Permanente Medical Groups

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

Patient Name: _____
Kaiser # _____ **Date of Birth:** _____
Address: _____
City: _____
State: _____ Zip Code: _____
Phone #: ( ) _____
Email: _____

Kaiser Permanente will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.

This authorizes the following Kaiser Permanente Medical Center(s): _____

to disclose information as specified below for the following purpose(s): DISABILITY RETIREMENT APPLICATION

Kaiser Permanente may disclose this information to:
☐ Check if same as above (disclosure to patient)
Recipient Name: MARIN COUNTY EMPLOYEES' RETIREMENT ASSN
Address: 1 MCINNIS PKWY, SUITE 100
City: SAN RAFAEL
State: CA Zip Code: 94903
Phone #: (415) 473-6147 Fax #: (415) 473-4179
Email: LMARTINEZ@MARINCOUNTY.ORG

Copies of records or medical record information within the following dates: _____ **to** _____

☑ Both Hospital and Medical Office Records ☐ Medical Office Records ☐ Hospital Records
☐ Records limited to a specific provider: _____ or department: _____
☑ X-Ray films ☑ X-Ray Digital Images ☑ Laboratory Results

NOTE: Hospital and Medical Office records may include disclosure of information related to mental health, alcohol/drug, and HIV references contained within those records as part of this authorization.

The actual treatment records from mental health, or alcohol/drug departments, or results of HIV antibody tests are specifically protected, and will not be disclosed unless you sign below.

Mental Health department records → Signature: _____
Alcohol / Drug dependency treatment records → Signature: _____
HIV antibody test results → Signature: _____

Media Type: ☑ Electronic ☐ Paper **Delivery Preference:** ☐ Email/Secure Portal ☑ Mail ☐ Pickup

DURATION: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here _____(date).

REVOCATION: You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.

REDISCLOSURE: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA). California recipients are required to obtain your authorization before further disclosing this information.

If you are requesting a form to be completed, we may substitute a standardized version of the form that provides the same or similar information requested.

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

Date _____ Signature _____ If not patient, print your name and relationship _____

SCAL: NS-9934 (6-12) SPANISH-NS-1614; CHINESE-NS-6274
NCAL: 90258 (REV. 6-12) SPANISH 01782-000; CHINESE 01782-002

ORIGINAL - DISCLOSING PARTY CANARY - PATIENT

UCSF Medical Center

UCSF Benioff Children's Hospital

DATE:

PATIENT NAME:

BIRTHDATE:

ID VERIFICATION (TYPE):

ID VERIFIED BY:

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize _____
(Name of person or facility which has information - example: UCSF/Mt. Zion)
to release health information to:
MARIN COUNTY EMPLOYEES' RETIREMENT ASSOCIATION

Name of person or facility to receive health information (full address)
MARIN COUNTY EMPLOYEES' RETIREMENT ASSOCIATION

Street address:
ONE MCINNIS PARKWAY, SUITE 100

City, State, Zip Code
SAN RAFAEL, CA 94903-2764

The purpose of this release is for (check one or more):

- ☐ Continuity of care or discharge planning
- ☐ Billing and payment of bill
- ☐ At the request of the patient/ patient representative
- ☒ Other (state reason) _____
  DISABILITY RETIREMENT APPLICATION

Please specify the health information you authorize to be released:

Type(s) of health information: ALL MEDICAL RECORDS, X-RAYS AND LAB RESULTS

Date(s) of treatment: PRESENT DATE THROUGH PREVIOUS FIVE (5) YEARS

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

- ☒ Information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).
- ☒ Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, *et seq.*)
- ☒ Release of HIV/AIDS test results (Health and Safety Code §120980(g)).
- ☐ Release of genetic testing information (Health and Safety Code §124980(j)).

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____(insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

_____ _____
Print Name | Signature (Patient, Parent, Guardian)

_____ _____
Date Time | Relationship to Patient (Parent, Guardian, Conservator, Patient Representative)

Requested format: ☐ Paper ☒ CD