



Please type or print clearly
in blue or black ink

Received Date

Application for Article 15 Disability Retirement

RS 6340
(Rev. 11/18)

NYSLRS ID

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Social Security Number [last 4 digits]

XXX-XX-

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Retirement System [check one]

Employees' Retirement System (ERS)

Police and Fire' Retirement System (PFRS)

Please return this application to the Retirement System in an envelope marked "Personal and Confidential Mail Drop 7-1"

INSTRUCTIONS: Please print plainly or type. The application must be signed on the reverse side.
Please call our Call Center at 1-866-805-0990 if you need help completing this application.

INFORMATION ABOUT YOU		
1. Name: (First, Middle Initial, Last)	2. Sex: <input type="checkbox"/> M <input type="checkbox"/> F	3. Date of Birth:
4. Address: (Including Street, City, State and Zip Code)		5. Telephone Numbers: HOME () WORK () CELL ()
6. Payroll Title:	7. Employer:	8. Length of Service: _____ years _____ months
9. Payroll Status: On Payroll & Receiving Salary? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Explain.		
10. I am permanently disabled because of the following medical condition(s): (Use additional sheets if required)		

11. I HAVE BEEN TREATED BY THE FOLLOWING DOCTORS: (Use additional sheets if required)		
Primary Care Physician:	Doctor:	Doctor:
Internal Med/Family Practitioner:	Medical Specialty:	Medical Specialty:
Street:	Street:	Street:
City, State and Zip Code:	City, State and Zip Code:	City, State and Zip Code:
Doctor:	Doctor:	Doctor:
Medical Specialty:	Medical Specialty:	Medical Specialty:
Street:	Street:	Street:
City, State and Zip Code:	City, State and Zip Code:	City, State and Zip Code:



Received Date

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

RS 6429
(Rev. 09/18)

Please type or print clearly
in blue or black ink

Patient Name: (First, Middle Initial, Last)	Date of Birth:	Social Security Number: XXX-XX-
Patient Address: (Including Street, City, State and Zip Code)		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in item 8(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in item 8(a), I specifically authorize release of such information to the person(s) indicated in Item 7.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from disclosing such information, without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (1-888-392-3644) or (212-961-8650). This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider(s) listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
5. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 8(b).**

6. Name and address of health care provider(s) or entity(ies) to release this information:

7. Name and address of person(s) or category of person to whom this information will be sent: New York State and Local Retirement System, Mail Drop 7-1, 110 State Street, Albany NY 12244
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8. (a) Specific information to be release:
- Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, insurance records, and records sent to you by other health care providers.
 - Other: _____ Include: *(Indicate by Initialing)*
- _____ **Alcohol/Drug Treatment**
 _____ **Mental Health Information**
 _____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) By initialing here _____ I authorize _____ to discuss my health information with my attorney or governmental agency listed here:

Initials Name of individual health care provider

 (Attorney/Firm Name or Government Agency Name)

9. Reason for release of information: <input type="checkbox"/> At the request of individual <input type="checkbox"/> Other: _____	10. This authorization will expire at the completion of the disability retirement application process:
11. If not the patient, name of person signing form:	12. Authority to sign on behalf of patient:

Signature of patient representative authorized by law Date

*Human Immunodeficiency Virus that causes AIDS. The New York State Public Health protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.