Application for Disability Checklist

San Joaquin County Employees' Retirement Association

IMPORTANT: In order for SJCERA to accept your application for disability retirement, you must **submit all of the following required documents to either 220 E. Channel St., Stockton, CA 95202 or disabilitycoordinator@sjcera.org** If an incomplete application is returned, a delay in services may occur.

☐ DISABILITY RETIREMENT APPLICATION

Every section of this form must be completed. Providing specific information will assist with the processing of your application. The form is available at www.sjcera.org and can be completed electronically and by hand with clear printing and dark ink. The form must be submitted in hard copy with an original signature.

☐ PHYSICIAN'S REPORT & STATEMENT

A completed statement or report 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). Your physician may either complete the form provided or address the same questions on physician's stationary.

☐ 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 or illness.

☐ SJCERA AUTHORIZATION FOR RELEASE OF MEDICAL, PSYCHIATRIC & EMPLOYMENT RECORDS & INFORMATION

Release forms generally give SJCERA the ability to gather all records relevant to the submitted application for disability retirement benefits. The following local providers require separate forms and are included in the packet for your convenience.

- ☐ San Joaquin County General Hospital
- ☐ Sutter Health
- ☐ Kaiser Permanente
- ☐ Dignity Health

If you have been treated by a provider not listed you may be asked to complete additional release forms.

☐ SUPPORTING MEDICAL RECORDS & REPORTS

It is your responsibility to provide SJCERA 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. Electronic copies of records (CD) preferred.

Disability Retirement Application

San Joaquin County Employees' Retirement Association

If after reading the Disability Retirement Fact Sheet and the Disability Retirement Process Fact Sheet you believe you qualify for a Disability Retirement Benefit, please complete this application and return it to SJCERA at **220 E. Channel St., Stockton, CA 95202** or email it to **contactus@sjcera.org**. If you have established reciprocity, apply with each system.

SECTION 1: MEMBER INFORMATION

Full Name: _____ DOB: _____

SSN or Member ID: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____

SECTION 2: APPLICATION TYPE

I have become permanently incapacitated from the performance of my duties and, accordingly, I hereby apply for: ☐ Service-connected disability retirement

☐ Nonservice-connected disability retirement

Are you interested in another job with the County of San Joaquin, which you could perform at no loss of income for you? ☐ Yes ☐ No

SECTION 3: RECIPROCITY (IF APPLICABLE)

You must file a separate retirement application with each reciprocal agency using the same retirement date.

Reciprocal System(s): _____

Dates of Membership (please list all): _____

SECTION 4: CURRENT EMPLOYMENT INFORMATION

Employer: _____ Department: _____

Hire Date: _____ Last Position Held: _____

Supervisor: _____ Last Work Day: _____

Current Employment Status (check all that apply):

☐ Working ____ hours per week

☐ Leave with compensation

☐ Leave w/out compensation

☐ Other: _____

☐ Not Working, still employed Receiving 4850 time

☐ Working modified schedule or with accommodation

☐ Resigned or terminated from service on: _____

☐ Retired on: _____

SECTION 5: ATTORNEY INFORMATION

You are entitled to legal representation at your own expense but you are not required to have an attorney. If you are or will be represented by legal counsel please provide your legal counsel's name and contact information in this section of your application. Your legal counsel will then be SJCERA's contact throughout this process.

Attorney Name: _____

Law Firm: _____ Phone:_____

Street Address: _____

City: _____ State: _____ Zip:_____

Email Address: _____

SECTION 6: DESCRIPTION AND ONSET OF SUBJECT INJURY OR ILLNESS

6A. Describe specifically the injury or illness that you claim is causing you to be permanently disabled from performing your duties:

6B. How and where did the injury or illness occur? Please answer completely, including the circumstances surrounding the occurrence, the location, time, name of the initial physician and a detailed description of what happened:

6C. Do you have any preexisting injury/illness which you now claim is being or has been accelerated or aggravated by the subject injury/illness?

☐ Yes ☐ No

6D. Please provide date of injury, and permanent condition:

Date you were injured or first noticed that you were ill: _____

Date you believe your disability became a permanent condition: _____

6E. If your disability is the result of a job-related injury, list all of the witnesses who observed the injury. Please use an additional sheet for additional witnesses if necessary.

Witness 1:

Full Name: _____ Relationship: _____

Work location: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Witness 2:

Full Name: _____ Relationship: _____

Work location: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Witness 3:

Full Name: _____ Relationship: _____

Work location: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

SECTION 7: DESCRIPTION AND ONSET OF SUBJECT INJURY OR ILLNESS

To be eligible for disability retirement, applicant must demonstrate that he/she is permanently incapacitated from substantially performing the essential duty(ies) of his/her job. Please attach a copy of the job description for the position that you currently hold and answer the questions below.

7A. Job Description Acknowledgement:

Is the job description accurate? ☐ Yes ☐ No

7B. Please list the additional duties you performed which are not included in the description:

7C. Also, list those duties included in the description which you did not perform on a regular and routine basis:

7D. Please list the essential functions of your position and whether you are able to perform them:

_____ ☐ Yes ☐ No _____ ☐ Yes ☐ No

_____ ☐ Yes ☐ No _____ ☐ Yes ☐ No

_____ ☐ Yes ☐ No _____ ☐ Yes ☐ No

_____ ☐ Yes ☐ No _____ ☐ Yes ☐ No

7E. State in detail the duties you cannot now perform due to your injury or illness.

SECTION 8: WORKERS' COMPENSATION RELATING TO SUBJECT INJURY OR ILLNESS

8A. Have you filed a Workers' Compensation claim relating to the injury or disease for which this disability retirement application is filed?

☐ Yes ☐ No

8B. If you answered "Yes" to question 8A, please complete the following:

Claim Number: _____

Date Claim Submitted: _____

Status of Claim: ☐ Pending ☐ Approved ☐ Denied

8C. If you answered "No" to question 8A, please explain why a claim was not submitted.

SECTION 9: PHYSICIAN INFORMATION RELATING TO SUBJECT INJURY OR 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 consulation, if known. Please include all physicians or health care providers with whome you have appointments scheduled for additional medical services in the furture that pertain to this injury or illness. Please attach a separate sheet of additional medical providers if necessary.

Medical Provider 1

Name: _____

Phone: _____ Date of Treatment: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Reason for visit: _____

Medical Provider 2

Name: _____

Phone: _____ Date of Treatment: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Reason for visit: _____

Medical Provider 3

Name: _____

Phone: _____ Date of Treatment: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Reason for visit: _____

SECTION 10: INFORMATION RELATING TO SIMILAR INJURY OR ILLNESS

10A. Have you ever received treatment for a similar injury or illness?

☐ Yes ☐ No

(If no, skip to Section 11)

10B. If you answered "Yes" to question 10A, please provide names, addresses, telephone numbers and dates of treatment for all physicians or health care providers on the next page. Indicate if the consultation resulted in a Workers' Compensation claim being filed.

Medical Provider 1

Name: _____

Phone: _____ Date of Treatment: _____

Workers Compensation Claim: ☐ Filed ☐ Not Filed

Street Address: _____

City: _____ State: _____ Zip: _____

Medical Provider 2

Name: _____

Phone: _____ Date of Treatment: _____

Workers Compensation Claim: ☐ Filed ☐ Not Filed

Street Address: _____

City: _____ State: _____ Zip: _____

Medical Provider 3

Name: _____

Phone: _____ Date of Treatment: _____

Workers Compensation Claim: ☐ Filed ☐ Not Filed

Street Address: _____

City: _____ State: _____ Zip: _____

SECTION 11: OTHER CURRENT AND PRIOR EMPLOYMENT

11A. 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 filled?

☐ Yes ☐ No

(If no, skip to 11C)

11B. If you answered "Yes" to question 11A, please list the employer or volunteer organization, address, telephone number, and your job duties on the next page.

Current Employer/Volunteer Organization 1

☐ Full-time ☐ Part-time ☐ Other: _____

Org Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Supervisor: _____ Phone: _____

Job Duties:

Current Employer/Volunteer Organization 2

☐ Full-time ☐ Part-time ☐ Other: _____

Org Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Supervisor: _____ Phone: _____

Job Duties:

Current Employer/Volunteer Organization 3

☐ Full-time ☐ Part-time ☐ Other: _____

Org Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Supervisor: _____ Phone: _____

Job Duties: _____

11C. Please list all prior employers (including other departments or agencies within the County), for whom you have worked in the last ten (10) years. Please attach a separate sheet if necessary.

Prior Employer 1

Org/Department: _____

Employment Dates: _____ to _____

Supervisor Name: _____

Supervisor Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Prior Employer 2

Org/Department: _____

Employment Dates: _____ to _____

Supervisor Name: _____

Supervisor Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Prior Employer 3

Org/Department: _____

Employment Dates: _____ to _____

Supervisor Name: _____

Supervisor Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

SECTION 12: INFORMATION RELATING TO THIRD PARTY (AS APPLICABLE)

12A. Is it possible that your injury 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 ***(If no, skip to Section 13)***

12B. If you are filing a disability retirement application due to the negligence of a third party, SJCERA has a fiduciary duty to ensure that a portion of the money received in a claim against a third party is returned to the fund to protect the benefits for all members. By submitting this application, you agree to notify SJCERA of any claims related to this application that you bring against a third party. 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

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

Third Party 1

Name: _____

Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Third Party 2

Name: _____

Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Third Party 3

Name: _____

Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

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

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: _____ Phone:_____

Street Address: _____

City: _____ State: _____ Zip:_____

Email Address: _____

SECTION 13: ADDITIONAL INFORMATION SUPPORTING DISABILITY APPLICATION

Include any further information you can offer to help the Board of Retirement in determining whether your application meets the criteria for a disability retirement. (Attach additional pages as necessary.)

SECTION 14: PHYSICIAN INFORMATION RELATING TO ALL OTHER HEALTH MATTERS

List the names, addresses and phone numbers of ALL physicians and health care providers consulted for any other reason during the five (5) years preceding the 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

Name: _____

Phone: _____ Date of Treatment: _____

Reason for visit: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Medical Provider 2

Name: _____

Phone: _____ Date of Treatment: _____

Reason for visit: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Medical Provider 3

Name: _____

Phone: _____ Date of Treatment: _____

Reason for visit: _____

Street Address: _____

City: _____ State: _____ Zip: _____

SECTION 15: APPLICANT SIGNATURE

This application does not replace any medical and/or other documentation which you 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 tests and records may result in rejection, delay or dismissal of your application.

I have submitted to SJCERA all pertinent medical records in support of my disability retirement application.

I have read and understand the Disability Policy and procedures, the Ex-Parte Communication Policy, the Disability Fact Sheet and the Disability Process Fact Sheet.

I agree to and understand the following:

- If I fail to submit documentation detailed on the application or the Disability Retirement Checklist, my application will be rejected.

- Refusal to submit to a medical examination shall result in a dismissal of the application.
- If I have established reciprocity with another public retirement system, I will submit a disability application with each reciprocal system and retire on the same date form each.
- I agree to promptly notify SJCERA of any claims, I bring against a third party and if I do not, SJCERA may pursue legal action against the third party or myself directly, to enforce the recovery rights of the fund.
- If I am a Safety Member and granted a Service Connected Disability Retirement based on presumption, the benefit will be reported as taxable.

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

Applicant Signature: _____ Date: _____

Authorized Employee Signature*: _____ Date: _____

Witness Signature: _____ Date: _____

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

Retirement Effective Date: _____

Safety Members Only - Presumption Addendum

San Joaquin County Employees' Retirement Association

SECTION 1: APPLICANT INFORMATION

Full Name: _____ DOB: _____

SSN or Member ID: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____

SECTION 2: SAFETY MEMBER PRESUMPTION

If you are a safety member: a firefighter, a probation officer, or a member in active law enforcement with five (5) or more years of completed service with SJCERA or another California public pension plan applying because you developed permanently incapacitating heart trouble, cancer, blood-borne infectious disease, PTSD, Lower Back Impairment, Tuberculosis, Meningitis, Hernia/Pneumonia, or exposure to a biochemical substance, your disability is presumed to be service connected. Please note that the claimed presumption is rebuttable/disputable by your Employer.

It is the members responsibility to prove service connection in order for a benefit to be reported as non-taxable to the IRS. Please complete the following section if your application is based on one of the presumptions.

This application is based on the following (Check all that apply):

- ☐ Heart
- ☐ Blood-Borne Infectious Disease
- ☐ Cancer
- ☐ Post-Traumatic Stress Disorder
- ☐ Tuberculosis
- ☐ Meningitis
- ☐ Hernia/Pneumonia
- ☐ Lower Back Impairment
- ☐ Known Exposure to a Biochemical Substance

To be considered for the presumptions of cancer and/or exposure to biochemical you must demonstrate you were exposed to a known carcinogen and/or biochemical substance in the course of your employment. Claiming general exposure during work-related situations is not sufficient. Please provide the following information to be eligible for the presumption. SJCERA will rely on IARC (International Agency for Research on Cancer) to recognize the carcinogen type.

Date of Exposure: _____

Circumstances of Exposure: _____

_____

_____

Type of Cancer (location on body): _____

_____

_____

Documentation Supporting Claim: _____

_____

_____

*Attach additional pages if necessary concerning the exposure or documentation of your claim.

I am an eligible safety member applying for service connected disability for one of the conditions stated above, however, I am applying not based on presumption and am providing evidence supporting job-connection to my disability. ☐ Yes ☐ No

Initial: _____ If yes, I have provided the medical records to support my disability.

☐ Copy of medical report/documentation is attached certifying that my disability for which I am applying for disability retirement under the presumption is service connected.

Determined by (Doctor): _____

Report Date: _____

Applicant Signature: _____

Date: _____

Witness Signature: _____

Date: _____

Physician Statement For Disability Retirement

San Joaquin County Employees' Retirement Association

Date: _____

Patient's Name: _____

Dear Doctor:

This employee of San Joaquin County has applied for a disability retirement. The employee must present medical evidence from a physician pertaining to the disabling illness or injury in connection with the application. Your completed Physician Statement will be included in the package of information sent to the Board of Retirement's panel physician.

Your evaluation should determine if the employee can perform the particular duties as outlined in the employer's job description. The employee will provide you with a copy of the Job Description. To be considered disabled under Retirement Law, the employee must be permanently incapacitated AND unable to perform a substantial portion of the task of his/her County job.

If you attach an earlier narrative report in lieu of filling out this form, please appropriately site pages that respond to each question. Please complete and sign the Physician Statement, and attach the Job Description. Return them to the patient. Failure to provide the information as requested, will cause the application to be rejected.

If you have any questions, please call the SJCERA office to speak with the Member Services Technician assigned.

Thank you,

Disability Coordinator
San Joaquin County Employees' Retirement Association
Member Services Technician

Enclosed

Patient's Name: _____

1. My medical specialty in the field of medicine is _____

2. The patient is (check one)

☐ **Substantially and permanently incapacitated** (This means that the patient is unable to accomplish one or more of the essential job functions of the position, as listed in the attached Job Description, that there is no reasonable accommodation which could be made to enable the patient to accomplish these essential job functions, and that patient's medical condition will not be improved enough for the patient to return to work in the future).

☐ **Temporarily incapacitated** (This means that the patient's condition will improve in the future enough for him or her to return to work or that there is a reasonable accommodation which the employer could make to enable the patient to accomplish these essential job functions, as listed in the attached Job Description.

☐ **Not incapacitated** (This means that with or without reasonable accommodations the patient is able to accomplish all of the essential job functions of his or her position, as described in the attached Job Description.

3. What is your diagnosis(es)?

_____

_____

_____

4. What objective findings support your diagnosis(es)?

_____

_____

_____

5. What are the symptoms related to this illness/injury?

_____

_____

_____

6. What functions of the job can the patient NOT PERFORM? Why? (Please be specific.)

7. Will the patient's condition improve enough to return to work? (Please explain your answer in detail.)

8. What is the prognosis for the patient returning to his/her job without medical intervention, surgery or other treatment?

9. Please discuss in some detail whether any reasonable accommodations or reasonable medical treatment, including surgery can be made which would allow the patient to accomplish the job duties listed in item #8. Your discussion should identify precisely what the recommended treatment consists of and the probability that the applicant can return to his/her former job position.

10. Did the applicant's employment with San Joaquin County contribute in any way to his or her permanent incapacity? Please state the facts supporting your answer. ☐ Yes ☐ No

11. Is the applicant's condition due to intemperate use of alcoholic liquor or drugs, or so far as the medical examination discloses, willful misconduct? Please state the facts supporting your answer. ☐ Yes ☐ No

12. I am the patient's: Treating Physician Examining Physician

13: Date patient last worked: _____

14. Dates patient under my care: _____ to _____

I attest that the patient has been continuously physically and/or mentally incapacitated to perform his or her duties since (initial by only one):

☐ The date patient last worked.

☐ The date the patient came under my care, if later than the last day worked.

I hereby certify the Physician's Statement is based on my examination and the attached Job Description of the patient's duties. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that this report was made the _____ (Day) day of _____ (Month), 20_____ (Year), at _____ (Street Address), City of _____ (City), CA.

Signature: _____ Date: _____

Name (Print): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Licensed to practice medicine under Laws of the State of California as Doctor of Specialty:

_____

_____

NOTE: This form must be signed by the physician to be valid.

Authorization to Obtain and Release Records and Information

San Joaquin County Employees' Retirement Association

HIPAA COMPLIANT AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEATLH INFORMATION

SECTION 1: MEMBER INFORMATION

Full Name: _____ DOB: _____

SSN or Member ID: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____

SECTION 2: AUTHORIZATION

In connection with my Application for Disability Retirement, I, the undersigned, hereby authorize you to release and provide any and all of my medical, psychiatric, psychological test and lab results, billing information and payment records to San Joaquin County Employees' Retirement Association (SJCERA.) I also hereby authorize SJCERA to procure and have in its possession all of the aforementioned medical information and records. I understand this includes, but is not limited to: hospital and other records; test results including X-rays, HIV tests, and lab reports; medical and psychological records, notes and reports and/or results from any service providers. This also includes records pertaining to alcohol and/or substance abuse treatment.

I hereby authorize you to release and provide any and all information, including sealed and unsealed documents in the Human Resources central personnel file, confidential files, Medical Disability Management file, Workers Comp file, Departmental file, payroll and other records, reports, and/or items concerning all my employment, past, current and future to SJCERA. I hereby authorize SJCERA to procure police, workers compensation investigative and /or other reports concerning any incident in which I have been involved.

I understand that copies of records and information released will be provided to SJCERA's Legal Counsel, SJCERA's Medical Advisor, and to my Employer (if requested) in connection with an independent review and or Medical Examination.

I understand SJCERA and my San Joaquin County participating Employer are materially relying on the information provided pursuant to this Authorization.

DURATION: I understand this release will be in effect and valid as long as my disability application is pending and for the time I receive disability retirement benefits 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.

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

Applicant Signature: _____ Date: _____

San Joaquin General Hospital
500 W. Hospital Road
French Camp, CA 95231
(209) 468–6000

AUTHORIZATION for RELEASE of INFORMATION

I, _____, hereby authorize
Patient or Legal Representative

San Joaquin General Hospital and Clinics to use or disclose my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal policy regulations.

Patient Name: _____ Med Rec/ID Number: _____

Date of Birth: _____ Sex: _____ SSN: _____

Persons/organization providing the information: Persons/organization receiving the information:

(From)	(To)
_____	_____
_____	_____
_____	_____

Specific Medical Condition(s): _____
And/or
Specific Timeframe(s): _____

What is the purpose of the disclosure? _____

(**Note:** "at the request of the individual" is a sufficient description of the purpose when the patient initiates the authorization and elects not to provide a statement of purpose.)

A. Type of Records Needed:

☐ Discharge Summary	☐ Outpatient Clinic Notes	☐ History and Physical
☐ Progress Notes	☐ Operative Reports	☐ Emergency Record
☐ Laboratory Test(s)	☐ Prenatal/Delivery Record	☐ Pathology Report(s)
☐ Consultation Report(s)	☐ Complete Medical Record	☐ Radiology Test(s)

☐ Other _____
_____

San Joaquin General Hospital
500 W. Hospital Road
French Camp, CA 95231
(209) 468–6000

AUTHORIZATION for RELEASE of INFORMATION

B. I specifically authorize release of the following information (check if appropriate):

- ☐ Alcohol/Drug Treatment Records
- ☐ HIV test results

NOTE: A separate authorization is required to authorize the disclosure of psychotherapy notes.

☐ All of the records marked above pertaining to me.
☐ Only the records from _____ Date(s) of Treatment

Exceptions: _____

I understand that this authorization shall become effective immediately and shall remain in effect until _____ (six months from date of signature).

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I understand that I may revoke this authorization at any time by completing the Revocation of Authorization Form, obtained from the Medical Records/HIM Department. The revocation will only be effective from the date it is received in this office and will not apply retroactively.

I further understand that I have the right to refuse to sign this form and that my refusal will not result in SJGH conditioning the provision of health care with two exceptions:

1. If it is for disclosure of information created for research that includes treatment.
2. If it is for disclosure of information created for the sole purpose of disclosure to a third party.

I also agree to pay any fees associated with copying, reviewing and mailing the requested records. I understand that I am entitled to receive a copy of this authorization.

I have a right to receive a copy of this authorization. If this box is checked, ☐ the Requestor will receive compensation for the use or disclosure of my information.

Print Name: _____

Signature: _____

Date: _____ Time:_____ am/pm

If signed by other than patient, indicate relationship: _____

Witness: _____

KAISER PERMANENTE®

(*Kaiser Permanente entities are listed on reverse side of this form)

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

Patient Name: _____

Medical Record number: _____ Birth Date: _____

Address: _____

City: _____ State: _____

Zip Code: _____ Phone #: ( ) _____

Email: _____

Kaiser Permanente may disclose this information to: ☐ Check if same as above

Recipient Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone # ( ) _____ Email: _____

This disclosure can be used for the following purpose(s): ☐ Personal Use ☐ Legal ☐ Insurance ☐ Medical Treatment ☐ Medical Condition Verification ☐ Disability ☐ FMLA ☐ Worker's Comp

Check one of the following three options to identify the health information to be released.

☐ **Option 1:** Form Completion (a substitute form or relevant medical records may be released)

☐ **Option 2:** Last 2 years of Kaiser Permanente Medical Office and Kaiser Foundation Hospital records

☐ **Option 3:** ☐ KP Medical Office ☐ Kaiser Foundation Hospital ☐ Immunization ☐ Lab Results ☐ Diagnostic Images ☐ Pharmacy ☐ Copays & Deductibles ☐ Itemized Billing

Complete as applicable
- ☐ For the specific date(s): _____
- ☐ For the specific provider(s): _____
- ☐ For the specific department(s): _____
- ☐ Other: _____

NOTE: Hospital and Medical Office records released as part of this authorization may contain references related to mental health, addiction, and HIV medical conditions.

Check the boxes below if you want this release to include the following information, Otherwise, this information will be excluded.

☐ Mental Health Treatment Records ☐ Addiction Medicine Treatment Records ☐ HIV Test Results

Media Type: ☐ Electronic ☐ Paper **Delivery Preference:** ☐ Electronic ☐ Mail ☐ Pickup

DURATION: Authorization shall remain in effect for one year from the date of signature below. However, in Washington, D.C. permission to release addiction medicine treatment records expires after six (6) months.

REVOCATION: You or your personal representative may cancel this authorization for future releases by submitting a written request to the Release of Information Unit listed for your region of service on the reverse side of this form. Your cancellation will not affect information that was released prior to receipt of the written request.

REDISCLOSURE: Once this information is released, it may not be protected under federal privacy law (HIPAA). State or other federal law may require the recipient to obtain your authorization before further disclosure.

Kaiser Permanente may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization. This disclosure is made at your request. For Virginia patients, a copy of this authorization, and a note stating to whom your information was disclosed will be included in your medical record. A copy of the original authorization is valid. You have a right to a copy of this completed authorization.

Date _____ Signature _____ If personal representative, print name/relationship _____

NS-9934 (7-15) SPANISH-NS-1614; CHINESE-NS-6274
NCAL: 90258 (REV. 7-15) SPANISH 01782-000; CHINESE 01782-002

ORIGINAL - DISCLOSING PARTY CANARY - PATIENT

See attached instructions for help with completing this form

Sutter Health

PATIENT LABEL

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

There may be fees incurred for this service.

Patient Information (*Tell us about the patient*)

Patient Name: _____ DOB: _____ MRN: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email (optional): _____

Type of Access Requested (*Please check ONLY one*)

☐ Paper Copy ☐ CD ☐ My Health Online ☐ Inspection Only ☐ Email (encrypted)

☐ Email (**not** encrypted) *(Note: If you would like us to send information over email not encrypted, this increases the risk that information could be read by an unauthorized third party.)*

☐ Other (must be agreed upon by the patient and provider): _____

Delivery Method (*Please check ONLY one*)

☐ Mail ☐ Email ☐ Fax ☐ Pick-Up (if applicable) ☐ My Health Online Portal

Purpose of Requested Use or Disclosure (*Tell us how you will use the records*)

☐ Continuity of Care – Appointment Date with Physician: _____

☐ Patient ☐ Insurance ☐ Other: _____

Authorization – I hereby authorize: (*Click dropdown or use attached list to select your Sutter care facility)*

_____

(Name of hospital, physician, healthcare provider)

_____

Address City State Zip

_____

Phone Fax

To release my health information to: ☐ Check this box if same as patient listed above. *OR*

_____

(Name of hospital, physician, healthcare provider, other)

_____

Address City State Zip

_____

Phone Fax

Information Disclosure (*Tell us what information you need*)

Information to be disclosed for the following date range _____ **to** _____:

☐ Hospital Records (Inpatient and Outpatient)

☐ Clinic/Foundation Records (Specify Provider Name): _____

☐ Radiology Report(s) Only

☐ Radiology Images (Specify): ☐ X-ray ☐ Ultrasound ☐ CT scan ☐ MRI ☐ Mammography

☐ Laboratory Test(s) Only

☐ Other: _____

Sutter Health

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Please mail or fax a copy of this Authorization form to the address or fax number shown on the attached address list for the Sutter Health affiliate where you received care. Complete one Authorization for each affiliate if you received care at more than one location. Thank You.

Special Authorization (*Tell us if we have permission to release the following sensitive information)*

I specifically authorize release of the following information:

☐ HIV test results _____ (initial) ☐ Substance abuse _____ (initial)
☐ Mental Health _____ (initial) ☐ Genetic testing _____ (initial)

Expiration

This authorization shall become effective immediately and shall remain in effect for one (1) year from the date signed unless a different date is specified here: _____

Restrictions

California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

Your Rights

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address:

For Sutter Hospitals:	**Palo Alto Medical Foundation**	**Sutter East Bay Medical Foundation**	**Sutter Gould Medical Foundation**	**Sutter Pacific Medical Foundation**	**Sutter Medical Foundation**
Sutter Shared Services	Attn: HIM Director	Attn: HIM Director	Attn: HIM Director	Attn: HIM Director	Attn: HIM Director
Attn: HIM Director	795 El Camino Real	3687 Mt Diablo Blvd. #200	600 Coffee Road	3883 Airway Dr. Suite 320	1014 N. Market Blvd. #10
P.O. Box 619091	Palo Alto, CA 94301	Lafayette, CA 94549	Modesto, CA 95350	Santa Rosa, CA 95403	Sacramento, CA 95834
Roseville, CA 95661					

- My revocation will be effective upon receipt, but will have no impact on uses or disclosure made while my authorization was valid.
- I have a right to receipt a copy of this authorization (required if authorization is requested for the provider's use or disclosure of health information).
- I may inspect and obtain a copy of the health information of which I am authorizing the use or disclosure of my health information.

If this box ☐ is checked, the facility listed above will receive compensation for the use or disclosure of my health information.

Signature (*As required by law*) ***Please print and manually sign. We do not accept e-signature at this time.***

SIGNATURE: _____ Date: _____ Time: _____
(Patient/Legal Representative)

If signed by other than the patient, print name and relationship:

Name: _____ Relationship: _____

Office Use Only Identification verified by (name): _____

Verified by (method): ☐ Photo ID ☐ Matching Signature ☐ Other: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient: _____ Date of Birth: _____

Other Names Used: _____ Telephone Number: _____

Medical Record or Account #: _____
(Hospital use only)

I AUTHORIZE: _____
(Facility or other provider)

Date(s): _____

TO DISCLOSE TO: _____
(Persons/organizations authorized to ***receive*** the information)

at the following address: _____
(street, city, state and zip code)

the following information contained in the records specified below (check box and initial applicable lines below):

____Mental health or developmental disability treatment records (excludes "psychotherapy notes")

____Substance abuse treatment records

____HIV test results (This authorizes disclosure of laboratory test results only. **Note that your records may include information concerning your HIV status <u>even</u> if you do not initial this line.)**

❑ **THE FOLLOWING RECORDS,** specific types of health information, or records for the date(s) of treatment as specified [check applicable box(es)]:

- ❑ Consultation Reports
- ❑ History and Physical
- ❑ Progress Notes
- ❑ Discharge Summary
- ❑ Laboratory Tests
- ❑ X-ray Reports
- ❑ Emergency Room Reports
- ❑ Procedure Reports
- ❑ Other: _____

❑ **ALL RECORDS** regarding my treatment, hospitalization, and outpatient care.
A separate authorization is required for the use or disclosure of psychotherapy notes or research health information.

Dignity Health.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

☐ MGH
☐ MHF
☐ MSJ
☐ MTH
☐ SNM
☐ WMH

ROI

SPSSSA20014 (1/17)
SPS.DOC

Patient Identification

Place Patient Label Here

PURPOSE: The purpose and limitations (if any) of the requested use or disclosure is:

- ❑ At the request of the patient or personal representative; ***OR***
- ❑ Other: _____

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified: _____
(insert date)

MY RIGHTS:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: Health Information Management, 10540 White Rock Road, Rancho Cordova, CA 95670. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

SIGNATURE: _____ Date: _____
(Patient or personal representative)

_____ _____
Print name of personal representative Relationship to patient

Patient/Representative Identification Verified. *Initials:* _____ *Dept:* _____

Note: If the **substance abuse treatment** information is protected by federal confidentiality rules (42 C.F.R. part 2) the following prohibition of re-disclosure statements must be provided to the recipient of the information:

The federal rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Dignity Health.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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Patient Identification

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