

AUTHORIZATION TO RELEASE RECORDS (OTHER THAN MEDICAL RECORDS)

Please complete this form and file it with the Ohio Police & Fire Pension Fund (OP&F) if you want OP&F to release any personal record that is deemed confidential under Ohio law. Records that are specifically excluded from inspection under Ohio law are records relating to:

- your family;
- address;
- employment history;
- salary history;
- pension amount;
- disability benefit amount;
- benefit application status; and
- medical records.

Once you have accepted a benefit, your status as a disability or service benefit recipient, the provision of law under which you retired, your disability award once accepted, and any other information permitted under OP&F's governing policies on the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a matter of public record, however, the amount of the benefit or other confidential information will not be disclosed without your authorization.

This authorization will remain in effect for the term of one year from the date you sign it, unless you rescind it in writing.

If you wish to release your medical records, please complete an *Authorization for OP&F to Release Medical Records* form, but note that Medical records can only be released to you, your attorney, personal physician, or designated agent. Please complete a *Designation of Agent* form to designate someone as an agent.

For more information, please contact OP&F Customer Service for assistance.

Section A — Member information

Name: first, middle initial, last, suffix (Jr., III, etc.)		Social Security number										
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Street / Post office box	Home telephone	Date of birth										
City, state, ZIP code	Alternate telephone	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>										

Section B — Release of records

Complete this section to designate the person or organization to receive the records indicated in Section C.

Person or organization	Name / title
QDRO Consultants / Pension Evaluators	
Phone number	Fax number
(330) 725-8685	(330) 722-2735
Address	City, state ZIP code
3071 Pearl Road	Medina, Ohio 44256

Section C — Type of record to release

Select which records you wish OP&F to release to the person listed in section B.

- Address
- Annuity payment plan
- DROP ledger
- Contribution history only
- Family information
- Gross monthly pension benefit amount/COLA amount or calculation
- Gross DROP amount
- Retiree check history
- Service credit only
- Salary history only
- Status of my application
- Member account detail report
- Membership dates (i.e. date of entry and effective date of retirement)
- Other _____
- Other _____
- Other _____
- Other _____
- Other _____

Section D — Signature and acknowledgement

I, the member described in Section A of this *Authorization to Release Records (other than medical records)* form, who, having been duly sworn, represent that I am the person herein described; it is my will and intent to authorize OP&F to release any information concerning the records I selected in Section C of this form to the person or organization named in Section B; I understand and agree that this authorization will be in effect for the term of one year from the date it is signed by me, unless I rescind it in writing; and waive my rights to any claim against OP&F, its employees, or the Board of Trustees which may result from the release of this information.

Member's Signature ▶	Date of Signature
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Section E — Notary Public requirement

The notary public in good standing, who witnessed the signature in section D, must sign in the space provided in this section and affix their seal.

State of Ohio, County of _____, ss:

The foregoing *Authorization to release records (other than medical records)* was acknowledged before me by the member named in the foregoing Section A, this _____ day of _____, 20_____.

Affix Seal Here	Notary signature
	Print name
	My Commission Expires