Ohio Public Employees Retirement System
277 East Town Street, Columbus, Ohio 43215-4642
1-800-222-PERS (7377) www.opers.org

Authorization for Release of Account Information

Ohio retirement law prohibits the release of confidential account information to a third party unless written authorization is provided by the member or retiree. **You or the third party must contact OPERS separately to request account information.** *This form cannot be used to initiate a request for information. This form will not authorize access to a member's or retiree's online account. Use this form to authorize the release of account information as described below.*

This form will not authorize the release of Protected Health Information (PHI) (re: a retiree or dependent's health care coverage). If you wish to authorize the release of PHI, please contact OPERS to request the HIPAA Authorization Form.

Section 1 - Member Personal Information

Social Security Number

Date of Birth **Month** **Day** **Year**

First Name **MI** **Last Name**

Street or Mailing Address **Apt. Number**

City **State** **ZIP Code** -

Home Phone Number **Work Phone Number** **Cell Phone Number**

E-mail Address

Section 2 - Type of Information to be Released - *This information will only be released when you or the third party contact OPERS separately to request account information. Select the records you wish OPERS to release to those you list in Section 3. You can contact OPERS separately by attaching a specific request to this form or by contacting OPERS at 1-800-222-7377 with your request after this form has been received and validated.*

- ☐ Service credit
- ☐ Contributions
- ☐ Earnable salary
- ☐ Value of account
- ☐ Estimate of retirement benefits
- ☐ Income verification
- ☐ Form 1099-R
- ☐ Disability medical records
- ☐ Breakdown of benefits
- ☐ Any/all account information (written and oral, excluding health care information)

Section 3 - Person(s) or Entity(ies) to Receive Information - *Complete this Section to designate the person(s) or entity(ies) to receive the information indicated in Section 2. If you wish to designate more than this Section allows, list them on a separate sheet of paper and include their address, phone and fax number. If you are using additional pages, please check this box.* ☐

1. ☐ Physician ☐ Attorney ☒ Authorized Agent

First Name William **MI** **Last Name** Napoli

Street or Mailing Address PO Box 39427

City Solon **State** OH **ZIP Code** 44139-

Phone Number 440 248 9150 **Fax Phone Number** 440 248 3585

2. ☐ Physician ☐ Attorney ☒ Authorized Agent

First Name Dennis **MI** A **Last Name** Napoli

Street or Mailing Address PO Box 39427

City Solon **State** OH **ZIP Code** 44139-

Phone Number **Fax Phone Number**

Section 4 - Member Authorization

As permitted by Section 145.27, Ohio Revised Code, and Ohio Admin. Code 145-1-61, I authorize the person(s) or firm(s) listed to request and receive the indicated information pertaining to my account with the Ohio Public Employees Retirement System.

This authorization is good *(check one)*:

☐ For 60 days ☐ For 90 days ☐ Indefinitely ☐ Until **Month** **Day** **Year**

If a date is not specified, the authorization will be good for 60 days from the date it was signed.

I ask that you honor copies or faxed transmissions of this authorization form. I acknowledge that additionally the original must be sent to OPERS for its membership records. I authorize OPERS to release the data indicated on this form to the person/organization indicated. I understand that I may provide written revocation of this authorization at any time prior to the authorization's expiration as provided above.

I understand that medical records can be released only to my physician, attorney, or agent or the Retirement Board's physician, per Ohio retirement law.

Member Signature_____ **Month** **Day** **Year**

Do not print or type name.