San Joaquin County Employees' Retirement Association

Application for Disability Retirement Checklist

In order for SJCERA to accept your application for disability retirement, you must submit all of the following required documents.

☐ 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 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 or illness.

☐ SJCERA Authorization for Release of Medical, Psychiatric and Employment Records and Information

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

- ☐ **San Joaquin General Hospital**
- ☐ **Sutter**
- ☐ **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 and 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.

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San Joaquin County Employees' Retirement Association

6 S. El Dorado St. STE 400 Stockton CA 95202 Tel: (209) 468-2163 • contactus@sjcera.org

DISABILITY RETIREMENT APPLICATION

Complete this application, if after reading the Disability Retirement Fact Sheet and the Disability Retirement Process Fact Sheet, you believe you qualify for a Disability Retirement Benefit. If you have established reciprocity, apply with each system.

SECTION 1: MEMBER INFORMATION

First Name	MI	Last Name	Last 4 digits of SSN

Address		Phone ☐ Cell ☐ Home	OR Employee ID Number

City	State	ZIP	Email	Date of Birth

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	DATE OF HIRE

LAST POSITION HELD	SUPERVISOR	LAST DATE WORKED

CURRENT EMPLOYMENT STATUS (CHECK ALL THAT APPLY)

☐ Not Working, still employed
☐ Working _____ hours per week
☐ Leave with compensation
☐ Leave without compensation
☐ Other:_____
☐ Receiving 4850 time
☐ Working modified schedule or with accommodation
☐ Resigned or terminated from service (date): _____
☐ Resigned or terminated from service (date): _____
☐ Retired on (date): _____

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		WORK PHONE

ATTORNEY ADDRESS			CELL PHONE

CITY	STATE	ZIP CODE	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 <u>permanently</u> 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 attending 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 On what date were you injured, or first noticed that you were ill? _____

On what date do 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. 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

SECTION 7: JOB DESCRIPTION AND ESSENTIAL FUNCTIONS

To be eligible for a 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 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 (Please include information on all claims.)

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

Claim Number: _____ Date Claim Submitted: _____

Status of Claim: ☐ Pending ☐ Approved ☐ Denied

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 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 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 10)*

10B If you answered "Yes" to question 10A, 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

SECTION 11: OTHER CURRENT AND PRIOR EMPLOYMENT INFORMATION

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 filed? ☐ 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.

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		

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

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

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

12A 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 (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

12C 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

12D If applicable, what is the status of your claim or lawsuit against the third party(ies)?

_____

_____

12E 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 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.)

_____

_____

_____

_____

_____

LAST NAME:
EMPLOYEE ID :

SECTION 14: 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 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		
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 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 from 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 upon 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 EMPLOYER SIGNATURE *	DATE *
WITNESS SIGNATURE	DATE

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

Retirement Effective Date:_____

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San Joaquin County Employees' Retirement Association

SAFETY MEMBERS ONLY
DISABILITY RETIREMENT APPLICATION- PRESUMPTION ADDENDUM

APPLICANT INFORMATION		
LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER

SECTION 15: 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, 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.

15.1 This Application is based up on of the following: Check all that apply.

☐ Heart trouble ☐ Blood-Borne infectious disease ☐ Cancer ☐ No exposure to a biochemical substance

15.2 To be considered for the presumption 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 of body) _____

_____

_____

Documentation Supporting Claim: _____

_____

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

15.3 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’s Statement

San Joaquin County Employees' Retirement Association

Date: _____

PHYSICIAN STATEMENT FOR DISABILITY RETIREMENT

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 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

6 South El Dorado Street, Suite 400 • Stockton, CA 95202
(209) 468-2163 • ContactUs@sjcera.org • www.sjcera.org

Patient's Name_____

PHYSICIAN'S REPORT

PLEASE TYPE OR PRINT IN INK

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 us of alcoholic liquor or drugs, or so far as the medical examination discloses, willful misconduct? Please state the facts supporting your answer.
    Yes. ☐ No ☐

Patient's Name_____

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

13. Date patient last worked: _____

14. Dates patient under my care: From _____ 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 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 of _____, 20__, at _____, City of _____, CA.,

Signature: _____ Date:_____

Name: (Print) _____

Address: _____

Phone No.: _____ Fax No.: _____

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.

Release of Information

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San Joaquin County Employees' Retirement Association

Authorization to Obtain and Release Records and Information

SECTION 1: Member Information			
First Name	MI	Last Name	SSN
Address			City/State/ZIP

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, (if requested) in connection with an independent review.

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

I acknowledge a photocopy of this document shall be as valid as the original. I understand this Authorization remains valid until the final determination of my request for disability retirement by SJCERA's Board of Retirement. I may request a copy of this Authorization at any time.

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.

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

Applicant Signature: _____ Dated: _____

6 South El Dorado Street, Suite 400 • Stockton, CA 95202
(209) 468-2163 • ContactUs@sjcera.org • www.sjcera.org

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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: _____

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): San Joaquin County Employees' Retirement Association

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: Disability Retirement Application

Authorization – I hereby authorize:

_____

(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*

San Jouquin County Employees' Retirement Association

(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

Complete one Authorization for each affiliate if you received care at more than one location.

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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)*

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: _____

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

Intentionally left blank

Patient's Request For Access To Protected Health Information

Date:_____ M.R. #: _____

Patient Name:_____ AKA/Other Names: _____

Date of Birth:_____ Phone: _____

Mailing Address:_____ City/State/Zip: _____

Covering the period of hospitalization from *(date)*_____ to *(date)*_____

You have requested access to health information about you. To allow us to process your request, please read the following carefully and complete the requested information below.

There may be fees associated with your request. The form in which you access your information may determine the amount of such fees.

A. You would like access to the health information about you maintained by Dignity Health as follows *(Check one)*.
- ☐ copy only *(Fees may apply. See attached price list.)*

B. You may obtain the following instead of a copy of the medical records:
- ☐ written summary of health information *(special report requested by physican - summary)*

C. Tell us which type of health information you want to access *(Check all that apply)*:
- ☐ See specific info below all records pertaining to date of service
- ☐ For my own use - - - - OR - - - - - ☐ For Doctor Follow-Up
- ☐ Procedure Report ☐ Emergency Room Records
- ☐ Discharge Summary ☐ Progress Notes
- ☐ History and Physical ☐ Laboratory Tests
- ☐ Consultation Reports ☐ X-ray Reports
- ☐ EKG
- ☐ Others *(please specify)* _____

The following classes of information are protected by special privacy laws and access may be subject to special rules or may be restricted under certain circumstances or access may require consultation with your physician or healthcare provider responsible for your care before release. If you are requesting access to records relating to **any** of the following, please initial each item that applies to confirm your request

_____HIV (Human Immunodeficiency Virus) Test Results **(To be released upon approval of your physician.)**
Initial

_____Psychiatric care **(To be released upon caregiver's approval.)**
Initial

_____Treatment for alcohol and/or drug abuse
Initial

Dignity Health.

PATIENT'S REQUEST FOR ACCESS TO PHI

- ☐ MGH
- ☐ MHF
- ☐ MSJ
- ☐ MTH
- ☐ SNM
- ☐ WMH

ROI

SPSSSA20015 (3/17)
SPS.QXP

Patient Identification

Place Patient Label Here

All patients' (or personal representative's) request(s) for access to their health information are processed in the order received upon the hospital's receipt and review of your request.

This request for access will not require Dignity Health to provide health information about you to anyone other than to you or your personal representative. If you request us to disclose health records or information about you to some other person, we may need a signed authorization **(a different form)** from you to allow us to transmit such information.

Return Address:

10540 White Rock Road, Suite 150
Rancho Cordova, CA 95670

I have read and confirm the terms of access stated herein.

Patient or Personal Representative's Signature	Date
Print Name if Other Than Patient	Telephone #
Relationship to Patient of Personal Representative	ID Presented
Name of hospital employee verifying signatory information	Title and Department

NOTIFICATION TO DOCTOR:_____ . Your patient has requested copies of their medical record. State / federal laws permit you to deny access in certain circumstances. Please notify us by _____ if you wish to deny access, otherwise we will provide copies of the record.

DATE RECORDS RELEASED/SENT:_____ PERSON RELEASING RECORDS:_____

CHW Policy 9.806

Dignity Health.

PATIENT'S REQUEST FOR ACCESS TO PHI

- ☐ MGH
- ☐ MHF
- ☐ MSJ
- ☐ MTH
- ☐ SNM
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SPSSSA20015 (3/17)
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Patient Name:_____ AKA/Other Names: _____

Date of Birth:_____ Phone: _____

Mailing Address:_____ City/State/Zip: _____

Covering the period of hospitalization from *(date)*_____ to *(date)*_____

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