Authorization for the Release of Information

In consideration of my application for total and permanent disability:

I, _____, hereby authorize any physician, hospital, or clinic to give full and complete information concerning me or my medical condition including any prior history to the Board of Trustees of the Policemen's and Fire Fighter's Retirement Fund of Lexington-Fayette urban County Government or their agents or designees, the Lexington-Fayette Urban County Government, or their agents or designees.

In addition to the above general medical release, I hereby specifically authorize the release of any records for which may exist concerning me, including but not limited to employment or personnel records with current or previous employers, including records with the Veteran's Administration, Social Security Administration, Worker's Compensation records or any other records which a personal release signed by me may be required.

This Authorization for Release of information is valid throughout the duration of my claim/retirement.

Please cooperate with the bearer of this release.

_____ _____

Signature Date

_____ _____

Printed Name Social Security Number

STATE OF KENTUCKY COUNTY OF: _____

On this day _____ of _____ , _____ the member whose name is signed above personally appeared before me and acknowledged the foregoing signature to be his/hers, and having been duly sworn by me, made oath that the statements made in the said instrument are true.

_____ _____

Notary Public Signature Date

_____ _____

Printed Name My Commission Expires