Authorization for the Release of Information

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 Police and Fire Retirement fund of the 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 that 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, Workers' Compensation records or any other records in which a personal release signed by me may be required.

This authorization is specifically intended to include any and all information of confidential or privileged nature as well as photocopies of such documents, if requested. This information will be used for the purpose of determining my eligibility for disability retirement benefits.

This authorization is valid throughout the duration of my claim/retirement.

Signature: ____ Date: ______________________

Printed Name: ____

<u>TO BE COMPLETED BY NOTARY PUBLIC:</u>

STATE OF KENTUCKY

COUNTY OF: ___________________

The foregoing instrument was acknowledged before me this ______ day of __________ (month),

________ (year), by ___________________________________ (name of person acknowledged).

Notary Public Signature: ____

Notary Public Printed Name: _____________________________ Date: ____________________

My Commission Expires: ________________________________

Commission Number: __________________________________