



# Authorization to Release Information

Colorado Public Employees' Retirement Association  
P.O. Box 5800, Denver, Colorado 80217-5800  
800-759-PERA (7372) • Fax: 303-863-3727 • [copera.org](http://copera.org)



Execution of this form does not authorize the release of information other than that specifically described below. Personal health information can only be released with the completion of the *Authorization to Use and/or Disclose Personal Health Information (PHI)* form.

## Member/Retiree SSN

\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|

## PERA Member/Retiree

Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
Birthdate \_\_\_\_\_ Email Address \_\_\_\_\_  
Month/Day/Year  
Sign up for electronic delivery of PERA information? Yes No

## Release Information To

**Complete the following information for the entity (company or organization) or individual to whom information is to be released.**

I request and authorize the Colorado Public Employees' Retirement Association (PERA) to release the information specified below to the entity or individual named on this *Authorization to Release Information*. I will complete a separate *Authorization to Use and/or Disclose Personal Health Information (PHI)* form should I choose to release personal health information.

Name \_\_\_\_\_ Entity or Individual  
Address \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
Telephone Number (\_\_\_\_) \_\_\_\_\_

## Information Requested

Categories of information limited to:	Time period for which information relates:
_____	_____
_____	_____
_____	_____
_____	_____

## Authorization

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Redislosure of the information released pursuant to this authorization by those receiving the above authorized information may not be accomplished without my further written consent.

**This consent will automatically expire three (3) years from the date executed by member/retiree, or earlier if indicated below (check box if applicable).**

Authorization will automatically expire in three (3) years OR LESS if one of the options are checked below:

- On \_\_\_\_\_; or
- If revoked in writing by member/retiree; or
- 180 days from the date executed; or
- Under the following condition(s): \_\_\_\_\_

**Sign Here → Signature of Member/Retiree \_\_\_\_\_ Date \_\_\_\_\_**

If the PERA participant is unable to sign this *Authorization to Release Information* for any reason, he or she may affix an "X" in the presence of two witnesses not related to the member. These two witnesses must sign below.

**Witness (other than family member) \_\_\_\_\_ Date \_\_\_\_\_**

**Witness (other than family member) \_\_\_\_\_ Date \_\_\_\_\_**

**Mail to: Colorado Public Employees' Retirement Association, P.O. Box 5800, Denver, CO 80217-5800**

