MFPRSI MUNICIPAL FIRE & POLICE RETIREMENT SYSTEM OF IOWA
7155 Lake Drive, Suite 201
West Des Moines, IA 50266

Notification of Temporary Disability

Part I – Information Provided by the City

According to Iowa Code Chapter 411.6(5), participating cities are required to notify MFPRSI if a member is temporarily incapacitated for at least 60 days or if the city expects a member to be temporarily incapacitated for at least 60 days. The statute provides that the medical board may consult with the member's treating physician during the period of incapacity.

City of: _____ ☐ Police ☐ Fire

Member's First Name | Member's Last Name | Last 5 Digits of SSN

Description of Disabling Condition:

Date of Disabling Event | Starting Date of Temporary Disability

Contact Information for Treating Physicians:

Name of Treating Physician	Address	Phone
Name of Treating Physician	Address	Phone
Name of Treating Physician	Address	Phone
Name of Treating Physician	Address	Phone

Please attach copies of available medical reports pertaining to each disabling condition

Comments:

Reporting Official Signature | **Title** | **Date**

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Part II – Patient's Authorization for Release of Information

Patient's First Name | Patient's Last Name | Maiden or Previous Names

Date of Birth | Last 5 Digits of SSN

A. Authorization for Release of Information

The undersigned hereby authorizes the city and all health care providers to disclose and deliver to the following:

MFPRSI
7155 Lake Drive, Suite 201
West Des Moines, IA 50266

Hereinafter referred to as "Recipient," the following information relating to the above-named patient:

A. Any and all information (to include, but not limited to all applicable medical records, x-rays, MRI's, test results, physician notes, etc.) EXCEPT substance abuse (drug or alcohol), mental health, and AIDS-related information which must be specifically authorized in Section IV below to be released;

or instead

☐ B. **ONLY** the following information (check only if applicable):

I understand the information is being disclosed and may be used only in connection with my Notification of Temporary Disability, my application for a disability pension from MFPRSI, and/or my reexamination for return to work.

B. Re-Disclosure

Iowa and/or Federal law provides that I have a right to prohibit re-disclosure of confidential medical information and further disclosure may not be had without my express written authorization, as indicated below.

I further understand that the Recipient, **without further authorization**, may re-disclose said information to:

A. Parties and their legal counsel, insurers, experts, potential experts, anyone against whom claim is or has been made, administrative agency and court officials hearing the claim, and any agents, employees, or representatives of any of said person;

or instead

☐ B. **ONLY** the following information (check only if applicable):

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Federal and/or State law specifically require that any disclosure or re-disclosure of substance abuse, alcohol or drug abuse, mental health, or AIDS-related information must be accompanied by the following written statement:

> "This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."
>
> See also Iowa Code Chapter 228 and Section 141.23(3) and other applicable laws.

Iowa Code Section 228.9 provides that psychological test material may be disclosed only to a licensed psychologist designated by the subject of the test. The section further provides that such material may not be disclosed to any other person, including the subject of the test.

C. General Authorization

I understand that I have a right to inspect the disclosed information at any time, SUBJECT TO IOWA CODE SECTION 228.9.

This Authorization is effective the date it is signed and continues to be effective for up to twelve (12) months past the date of signature. I understand that I may revoke this Authorization in writing at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider or record keeper.

A photocopy or exact reproduction of this signed Authorization shall have the same force and effect as this original.

I hereby authorize the release of the information as indicated above.

I understand that for the above information to be released, I must sign below:

_____ _____
Signature of Patient or Legal Guardian Date of Signature

_____
Street Address

_____ _____ _____
City State Zip

_____
Relationship, if NOT the patient

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D. General Authorization

Complete this section only if there are medical records related to substance abuse, mental health, or aids-related information

I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, and/or AIDS-related information.

I **specifically authorize** the release of confidential information relating to:

Please check "yes" or "no" as applicable.

☐ Yes ☐ No Substance Abuse (drug or alcohol) Information. If "yes," please identify the name of the treating agency, facility, physician or counselor:

☐ Yes ☐ No Mental Health Information. If "yes," please identify the name of the treating agency, facility, physician or counselor:

☐ Yes ☐ No AIDS-related Information, Diagnosis, and test results. If "yes," please identify the name of the treating agency, facility, physician or counselor:

Furthermore, I **specifically authorize** disclosure and re-disclosure of this confidential information to all the persons referred to in Section II above.

Signature of Patient or Legal Guardian

Date of Signature

Relationship, if NOT the patient

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Part III: Information about Your Medical Records

Please print, type, or write clearly and answer all items to the best of your ability. If you are filing on behalf of someone else, enter his or her name and social security number in the space provided and answer all questions. Complete answers will aid in processing the application.

Member Information:

First Name _____ Last Name _____ Last 5 digits of SSN _____

1. List the name, address and telephone number of the **doctor** who has the latest medical records about your disabling condition. If you have **no** doctor, check: ☐

Doctor's Name _____ Clinic _____

Street Address _____ City _____ State _____ Zip _____

Doctor's Email _____ Doctor's Phone _____

How often do you see this doctor? _____

Date you **first** saw this doctor: _____ Date you **last** saw this doctor: _____

Were x-rays taken? Yes ☐ No ☐ Were MRIs taken? Yes ☐ No ☐

Reasons for visits (show illness or injury for which you had an examination or treatment):

Type of treatment or medicines received (e.g., surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known). If no treatment or medicines, write "NONE".

2. If you have seen other **doctors** since your disabling condition began, please show the following:

Doctor's Name _____ Clinic _____

Street Address _____ City _____ State _____ Zip _____

Doctor's Email _____ Doctor's Phone _____

How often do you see this doctor? _____

Date you **first** saw this doctor: _____ Date you **last** saw this doctor: _____

Were x-rays taken? Yes ☐ No ☐ Were MRIs taken? Yes ☐ No ☐

Reasons for visits (show illness or injury for which you had an examination or treatment):

Type of treatment or medicines received (e.g., surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known). If no treatment or medicines, write "NONE".

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3. Identify any other **doctors** you have seen since your illness or injury began:

Doctor's Name _____ Clinic _____

Street Address _____ City _____ State _____ Zip _____

Doctor's Email _____ Doctor's Phone _____

How often do you see this doctor? _____

Date you **first** saw this doctor: _____ Date you **last** saw this doctor: _____

Were x-rays taken? Yes ☐ No ☐ Were MRIs taken? Yes ☐ No ☐

Reasons for visits (show illness or injury for which you had an examination or treatment):

Type of treatment or medicines received (e.g., surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known). If no treatment or medicines, write "NONE".

4. Have you been **hospitalized or treated at a clinic** for your disabling condition? Yes ☐ No ☐
If "yes," provide the following information:

Name of Hospital or Clinic

Street Address _____ City _____ State _____ Zip _____

Hospital Phone _____ Patient or Clinic Number _____

Were you an inpatient (i.e., stayed overnight?) Yes ☐ No ☐
If "**yes**," provide the following information:

Were x-rays taken? Yes ☐ No ☐ Were MRIs taken? Yes ☐ No ☐

Dates of Admissions: _____

Dates of Discharges: _____

Were you an outpatient? Yes ☐ No ☐
If "**yes**," provide the following information:

Dates of Visits: _____

Were x-rays taken? Yes ☐ No ☐ Were MRIs taken? Yes ☐ No ☐

Reasons for hospitalizations/clinic visits (show illness or injury for which you had an examination or treatment):

Type of treatment or medicines received (e.g., surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known). If no treatment or medicines, write "NONE".

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5. If you have been in other **hospitals or clinics** for your disabling condition, identify below:

Name of Hospital or Clinic

Street Address | City | State | Zip

Hospital Phone | Patient or Clinic Number

Were you an inpatient (i.e., stayed overnight?) Yes ☐ No ☐

If "**yes**," provide the following information:

Dates of Admissions:

Dates of Discharges:

Were you an outpatient? Yes ☐ No ☐

If "**yes**," provide the following information:

Dates of Visits:

Were x-rays taken? Yes ☐ No ☐ Were MRIs taken? Yes ☐ No ☐

Reasons for hospitalizations/clinic visits (show illness or injury for which you had an examination or treatment):

Type of treatment or medicines received (e.g., surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known). If no treatment or medicines, write "NONE".

Provide Additional Information, if necessary: