FIRE & POLICE PENSION PLAN

SURVIVOR

GENERAL INFORMATION

Application - Processing – Options

CITY OF LOS ANGELES
Fire and Police Pension System

Department of Fire and Police Pensions
701 East 3rd Street, Suite 200
Los Angeles, California 90013
Toll Free #: (844) 88-LAFPP (52377)
Phone #: (213) 279-3165
Fax #: (213) 628-7782

Revised October 2023

EVERY EFFORT HAS BEEN MADE TO PROVIDE ACCURATE INFORMATION IN THIS BOOKLET. IF THERE IS A DIFFERENCE BETWEEN THE CONTENTS OF THIS BOOKLET AND THE CHARTER/ADMINISTRATIVE CODE, THE PROVISIONS OF THE CHARTER/ADMINISTRATIVE CODE SHALL APPLY.

INFORMATION SHEET FOR SURVIVING SPOUSE / DOMESTIC PARTNER

This information sheet is provided to answer some of the most frequently asked questions by surviving spouses/domestic partners.

1. WHAT HAPPENS NEXT?

Your completed application for surviving spouse/domestic partner benefits should be accompanied by a certified death certificate and copies of all applicable marriage/minor child birth certificates. Your application will be processed by the Disability Pensions Section and considered by the Board of Fire and Police Pension Commissioners. After Board approval, you will be advised by letter of the exact amount of your pension, including any applicable retroactive and cost of living amounts, and when to expect your first check. Please be aware that the process to award service-connected survivor benefits may take up to one year or longer.

2. IS MY PENSION TAXABLE?

If you receive a nonservice-connected surviving spouse pension, it is taxable. If you receive a service-connected surviving spouse pension, it is generally non-taxable.

3. WHAT IS WITHHELD/DEDUCTED FROM MY PENSION CHECK?

State of California and Federal taxes will be automatically withheld from your pension check at the rate of married with three deductions. If you wish State and/or Federal taxes to be withheld from your pension check at a different rate, you must complete the attached Form W-4P and return it to our Retirement Services Section.

Additionally, your check may be reduced due to a Workers' Compensation death benefit recapture, which is required by the Los Angeles City Charter. Deductions made pursuant to this requirement may include:

1. Concurrent Payments – This amount may include any Workers' Compensation payments made to you while your survivor application is being processed up to the date of any Board action. This amount may be significant and would be offset from any initial pension payment (if granted).
2. Continuing Payment – If you continue to receive Workers' Compensation payments after a pension is awarded, these same amounts may be deducted from your pension payment.

Since each situation is unique, please contact the Accounting Section at (213) 279-3040 with any questions.

4. APPLICATIONS FOR SURVIVOR PENSION BENEFITS RESULTING FROM DEATH BY SUICIDE

When the cause of death is the result of suicide, and the survivor applies for service- connected benefits, the applicant must provide documentation indicating that he/she is the "personal representative" of the deceased member's estate. Acceptable documentation includes a valid and enforceable trust, will, or court order that identifies the applicant as the deceased member's personal representative. Without this documentation, medical providers will not release the deceased member's psychological or medical records, which LAFPP requires for processing a survivor application where suicide is associated with the cause of death. LAFPP will not accept a survivor application filed without the required documentation.

5. WHO SHOULD I CONTACT IF I HAVE QUESTIONS ABOUT MY PENSION?

You may contact the Retirement Services Section at (213) 279-3125 if you need information pertaining to your pension.

6. IS DIRECT DEPOSIT AVAILABLE?

Yes. To sign up for direct deposit, fill out the attached Direct Deposit Form and return it to our Retirement Services Section. For more information, please call the Retirement Services Section at (213) 279-3125.

7. HOW DO I REPORT AN ADDRESS CHANGE?

Departmental policy requires written notification, signed by you, of all address changes. Any changes should be faxed/mailed to:

DEPARTMENT OF FIRE AND POLICE PENSIONS
Retirement Services
Section 701 East 3rd
Street, Suite 200 Los
Angeles, CA 90013 Fax:
(213) 628-7716

You may also use MyLAFPP to process address changes and sign up for or make changes to your direct deposit.

8. WILL I BE ABLE TO CONTINUE MY PRESENT HEALTH OR DENTAL INSURANCE?

Information regarding continuing health or dental benefits may be obtained from your current health or dental care provider..

UFLAC	(213) 895-4006
FIREMEN'S RELIEF	(323) 259-5200 or (800) 244-3439
POLICE PROTECTIVE LEAGUE	(213) 251-4554 or (800) 525-2775
POLICE RELIEF	(213) 674-3701 or (888) 252-7721

Los Angeles Fire and Police Pensions
Board of Pension Commissioners
Attn: Retirement Services Section
701 East 3rd Street, Suite 200
Los Angeles, California 90013-1865

APPLICATION FOR SURVIVOR PENSION BENEFITS

Applicant Name _____

Social Security # _____ Date of Birth _____ Email _____

Address _____ Mobile Number _____

_____ Telephone Number _____

Applicant is the qualified surviving spouse or qualified surviving domestic partner of the following deceased member of the Fire and Police Pension System:

Name of Member _____ Department _____

Social Security # _____ Date of Death _____

TO BE COMPLETED BY DEPARTMENT ONLY

Rank of Member Years of Service

Date of Retirement

Pension Plan of Member Tier 1 Tier 2 Tier 3 Tier 4 Tier 5 Tier 6

Type of Pension Service S/C Disability NON-S/C Disability

SBPP Election Date SBPP Vested Date SBPP Percentage

Marriage Information*

Applicant was legally married to member on _____ Place of Marriage _____

*** To be eligible for surviving spouse benefits applicant must have been married to the member:*
a) for at least one year prior to the member's retirement on a service pension or non-service connected disability pension; or
b) on or before the effective date of the member's service-connected disability pension.
For post-retirement marriages, survivor benefits may be available to the applicant, if the member prior to his/her death, had elected, purchased and vested in the Survivor Benefit Purchase Program (SBPP) for the benefit of such applicant.

Domestic Partner declarations must be on file with the Board of Fire and Police Pension Commissioners and are subject to the same provisions of the Administrative Code and eligibility requirements as a qualified surviving spouse.

Minor Children (unmarried, natural or legally adopted children of the member under the age of 18)*
and/or
Adult Dependent Children

Name Date of Birth-Place of Birth Social Security Number

_____

_____

_____

*** Tiers 3, 4, 5 and 6 Minor Children remain eligible for pension benefits up to age 22, if proof of full-time student status is submitted.*

Applicant declares under penalty of perjury that all the foregoing is true and correct:

Signature _____ Date _____

Subscribed and sworn to before me on _____

Notary Public _____ (Seal)

APPLICATION FOR SURVIVING SPOUSE PENSION BENEFITS

BOARD OF FIRE AND POLICE PENSION COMMISSIONERS
OF THE CITY OF LOS ANGELES

1. History of Member's Medical Treatment:

A. Illness or Injury	Date(s)

B. Doctors or Hospitals where Treated	Date(s)
Name	
Address	
Name	
Address	
Name	
Address	

2. Doctors or hospitals where treatment was rendered for any illness or injury other than those illnesses or injuries claimed as the basis for this application (e.g., family physician, medical clinic, or Health Maintenance Organization such as Kaiser, Blue Cross, etc.).

NAME	Address
NAME	Address
NAME	Address
NAME	Address
NAME	Address

PLEASE READ THE FOLLOWING CLOSELY BEFORE SIGNING

By initialing the following, I attest that I have read and understand that:

_____ 1. In order to receive service connected survivor pension benefits under the provisions of the City Charter, the Board of Fire and Police Pension Commissioners must have sufficient evidence to find that the decedent's death resulted from the performance of his/her essential job functions. The Administrative File, created in the course of the survivor pension benefit application process, may also be supplemented by other evidence pertinent and relevant to the issues of service connection.

_____ 2. The medical and personnel information contained in the Administrative File will be available to individuals involved in the processing of my claim, including but not limited to, the Board of Fire and Police Pension Commissioners, City Attorney staff, physicians performing evaluations and record reviews for the Board, Personnel Department and contracted Workers' Compensation staff, and the decedent's employing Department Medical Liaison.

_____ 3. I have, at my own expense, the option to be represented by legal counsel in the proceedings before the Board of Fire and Police Pension Commissioners or I may request the assistance of an employee organization. Should I choose to secure representation, I shall notify the Department of Fire and Police Pensions in writing within ten (10) days of obtaining representation.

_____ 4. If I am granted a survivor pension benefit and also receive a Workers' Compensation Death Benefit award, or have already received a Workers' Compensation Death Benefit award, the amount of the award will be fully recovered by the City of Los Angeles as provided in the City Charter. The Manager-Secretary is authorized to reduce the monthly pension amount payable to me on an installment basis until the total amount of compensation has been offset. This installment reduction shall be at the discretion of the Manager-Secretary but shall not be less than twenty-five percent (25%) of the gross monthly pension amount which would be payable but for the offset. Of the first payment or any retroactive payment, up to 100% of any retroactive pension payment will be applied to the Workers' Compensation Death Benefit offset.

I declare under penalty of perjury that all of the foregoing is true and correct.

Date _____ Signature _____

The City of Los Angeles
Department of Fire and Police Pensions
Disability Pensions Section
701 E. 3rd Street, Suite 200
Los Angeles, CA 90013

Honorable Members:

As the survivor of_____ I am herewith submitting an application to receive pension benefits that I may be entitled to under Tier_____ of the City Charter/Administrative Code.

In order to begin receiving pension benefits as soon as possible, I wish to have my application processed as a NONSERVICE-CONNECTED SURVIVOR'S PENSION without prejudice, or a SERVICE PENSION CONTINUANCE (if member was in DROP) which provides benefits at no less than the rate of 40 percent of final salary for highest paid police officer's or firefighter's rank (Tier 2) or; 30 percent of final one year average salary (Tier 3, 4, 5), 50% of Member's final average salary (Tier 6), or 55 percent of normal pension base (Tier 2), 60 percent of Member's pension benefit (Tier 3, 4, 5), 70 percent of Member's service pension (Tier 6) if in DROP.

I understand that this does not prejudice my right of pursuing SERVICE-CONNECTED SURVIVOR'S PENSION benefits provided I notify the Department of Fire and Police Pensions no later than 180 days from the date the Board approves a NONSERVICE-CONNECTED PENSION/SERVICE PENSION CONTINUANCE, of my intent to pursue a SERVICE-CONNECTED PENSION. I agree to assist the Department of Fire and Police Pensions in obtaining appropriate medical and other related materials to support my request.

I also understand that in the event the Board does convert my NONSERVICE-CONNECTED/SERVICE PENSION CONTINUANCE pension benefits to SERVICE-CONNECTED status, I will receive retro-actively any accrued difference between the two pension benefit plans for the period of time that I received NONSERVICE-CONNECTED/SERVICE PENSION CONTINUANCE pension benefits.

_____	_____
Print Name	Signature of Applicant
_____	_____
Date	Social Security Number
_____	_____
Email Address	Telephone Number

AUTHORITY TO RELEASE MEDICAL AND PSYCHIATRIC RECORDS
OF

_____ _____
(Print Member's Full Name) (Applicant's Cell/Home/Work Phone #)

_____ _____
(Member's Social Security #) (Member's Birth Date)

Date:

To:

Send Records To:

THE CITY OF LOS ANGELES
DEPT. OF FIRE AND POLICE PENSIONS
Disability Pensions Section
701 E. 3rd Street, Suite 200
Los Angeles, CA 90013

This will be your authority to release to the Department of Fire and Police Pensions (LAFPP) and the Board of Fire and Police Pension Commissioners of the City of Los Angeles any information requested in connection with the medical history of the above named individual, including all records relating to any Workers' Compensation claims. This information is to be used only in the processing or review of an application for disability pension benefits. I further authorize the Department of Fire and Police Pensions and the Board of Fire and Police Pension Commissioners to release such information to pension doctors on behalf of said Board. This authorization shall be considered valid for five (5) years from the date signed. (Copies of this authorization will be considered as valid as the original.)

_____ _____
(Date) (Authorized Signature)

Please release the following records:

- ☐ Emergency Room Reports
- ☐ All Hospitalization Records
- ☐ Admission Reports
- ☐ Physical Exam/History
- ☐ Operation Reports
- ☐ Discharge Summary
- ☐ Workers' Compensation Records
- ☐ Doctor's Reports
- ☐ Treatment Records
- ☐ Imaging Reports
- ☐ Test Results
- ☐ Psychiatric Records

Other:_____

LAFPP is not a healthcare provider, healthcare clearinghouse, or health plan, therefore, "is not" subject to HIPAA regulations. (Public Law 104-191: Section 1171)

Your prompt attention to this matter will be appreciated. If you have any questions, feel free to call Benefits Analyst_____at the Department of Fire and Police Pensions, Disability Section: (213) 279-3165, Fax (213) 628-7782.

[The person releasing the above-described records, as well as the patient to whom it pertains, are entitled to receive a copy of this authorization upon demand. (California Civil Code, Part 2.6 Section 56 et. seq. added by Stats 1981A "Confidentiality of Medical Information Act")].

AUTHORITY TO RELEASE EMPLOYMENT RECORDS
OF

_____
(Member's Full Name)

_____ _____
(Member's Social Security #) (Member's Birth Date)

Date:

To:

Send Records To:

THE CITY OF LOS ANGELES
DEPT. OF FIRE AND POLICE PENSIONS
Disability Pensions Section
701 E. 3rd Street, Suite 200
Los Angeles, CA 90013

This will be your authority to release to the Department of Fire and Police Pensions and the Board of Fire and Police Pension Commissioners of the City of Los Angeles the following information requested in connection with the employment history of the above named individual.

Please provide the below-named Benefits Analyst at the Department of Fire and Police Pensions with copies of any and all personnel records including all disciplinary files, job description, position title, performance evaluations, payroll records, length of employment, hours worked, sick or injury reports, pre-employment physical examination records, and date and time of absences from work.

This information is to be used only in the processing or review of an application for disability pension benefits. I further authorize the Department of Fire and Police Pensions and the Board of Fire and Police Pension Commissioners to release such information to pension doctors on behalf of said Board. This authorization shall be considered valid for five (5) years from the date signed. (Copies of this authorization will be considered as valid as the original.)

_____ _____
(Date) (Signature)

Your prompt attention to this matter will be appreciated. For clarification or further information, please feel free to contact Benefits Analyst_____at (213) 279-3165, Fax (213) 628-7782.

[The person releasing the above-described records, as well as the patient to whom it pertains, are entitled to receive a copy of this authorization upon demand. (California Civil Code, Part 2.6 Section 56 et. seq. added by Stats 1981A "Confidentiality of Medical Information Act")].

AUTHORITY TO RELEASE SUBSTANCE ABUSE PATIENT RECORDS
OF

_____
(Member's Full Name)

_____ _____
(Last Four of Member's Social Security #) **(Member's Birth Date)**

Date:

To:

Send Records To:

THE CITY OF LOS ANGELES
DEPT. OF FIRE AND POLICE PENSIONS
Disability Pensions Section
701 E. 3rd Street, Suite 200
Los Angeles, CA 90013

I,_____, hereby authorize_____
(Name) (Name of Organization)

This will be your authority to release information and records pertaining to the treatment and/or hospitalization of the above named individual for substance abuse or chemical dependency to the City of Los Angeles Department of Fire and Police Pensions and the Board of Fire and Police Pension Commissioners.

Disclosure of requested records shall be limited to the following specific types of information: admission summaries; history and physical examination reports; laboratory data including blood chemistries and urinalyses; treatment reports; pharmacy and prescription orders; physicians', therapists', and nurses' notes/orders; and discharge summaries.

The purpose of this request for records is to assist the Department of Fire and Police Pensions in the processing or review of an application for disability pension benefits. This authorization shall be considered valid for five (5) years from the date signed.

I certify that I have read, understand, and agree with the above provisions of this consent.

_____ _____
(Date) (Signature)

LAFPP is not a healthcare provider, healthcare clearinghouse, or health plan, therefore, "is not" subject to HIPAA regulations. (Public Law 104-191: Section 1171)

Your prompt attention to this matter will be appreciated. If you have any questions, feel free to call Benefits Analyst_____at the Department of Fire and Police Pensions, Disability Section: (213) 279-3165, Fax (213) 628-7782.

[The person releasing the above-described records, as well as the patient to whom it pertains, are entitled to receive a copy of this authorization upon demand. (California Civil Code, Part 2.6 Section 56 et. seq. added by Stats 1981A "Confidentiality of Medical Information Act")].

The City of Los Angeles
Department of Fire and Police Pensions
Disability Pensions Section
701 E. 3rd Street, Suite 200
Los Angeles, CA 90013

To Whom It May Concern:

SUBJECT: Request to Pursue Service-Connected Benefits

As the survivor of_____, I was granted a NONSERVICE-CONNECTED SURVIVOR'S PENSION without prejudice fewer than 180 days ago.

At this time I respectfully request that processing of my original application be continued and that the Board consider converting my pension benefits to SERVICE-CONNECTED.

_____ _____
Date Applicant's Signature

_____
Print Name

_____
Social Security Number

The City of Los Angeles
Department of Fire and Police Pensions
Disability Pensions Section
701 E. 3rd Street, Suite 200
Los Angeles, CA 90013

To Whom It May Concern:

SUBJECT: Request to Pursue Service-Connected Benefits

As the survivor of_____, I was granted a SERVICE PENSION CONTINUANCE SURVIVOR'S PENSION fewer than 180 days ago.

At this time I respectfully request that processing of my original application be continued and that the Board consider converting my pension benefits to SERVICE-CONNECTED.

_____ _____
Date Applicant's Signature

_____
Print Name

_____
Social Security Number

ATTORNEY AUTHORIZATION

The City of Los Angeles
Department of Fire and Police Pensions
Disability Pensions Section
701 E. 3rd Street, Suite 200
Los Angeles, CA 90013

I hereby authorize _____
(Name)

_____,
(Address) (Telephone #)

as the attorney of record, to act as my representative in all matters relating to the processing or review of my application for disability pension benefits and for the purpose of representing my claim before the Board of Fire and Police Pension Commissioners. This will be your authority to release to my attorney any information from my Administrative File.

I understand that I shall be held to all scheduled dates and times agreed to by my representative and a change in representation status will not automatically be sufficient cause to delay the processing of my claim.

_____ _____
Print Name Signature

_____
Date

The above named attorney or law firm accepts the responsibility as the attorney of record for representing this applicant in all matters relating to the processing or review of the application for disability pension benefits and before the Board of Fire and Police Pension Commissioners.

_____
Signature of Attorney or
Authorized Law Office Staff

_____
Date

REPRESENTATIVE AUTHORIZATION

The City of Los Angeles
Department of Fire and Police Pensions
Disability Pensions Section
701 E. 3rd Street, Suite 200
Los Angeles, CA 90013

I hereby authorize _____,
(Name)

_____
(Organization registered with City Clerk's Office)

_____,
(Address) (Telephone #)

to act as my representative in matters relating to the processing or review of my application for disability/survivorship pension benefits and for the purpose of representing my claim before the Board of Fire and Police Pension Commissioners. This will be your authority to release to my representative any information from my Administrative File.

I understand that I shall be held to all scheduled dates and times agreed to by my representative and a change in representation status will not automatically be sufficient cause to delay the processing of my claim.

_____ _____
Print Name Signature

_____
Date

_____

The above named representative accepts the responsibility for representing this applicant in matters relating to the processing or review of the application for disability/survivorship pension benefits before the Board of Fire and Police Pension Commissioners.

_____
Signature of Authorized Representative

_____
Date

KAISER PERMANENTE®

(*Kaiser Permanente entities are listed on reverse side of this form)

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED 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 release 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 ❑ Workers' Comp

Check ONLY 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:** Records as specified. You must complete Step 1 and Step 2 below.

Step 1. Enter date range or date(s) of the records to be released: _____

Step 2. Select types of records to be released:

❑ KP Medical Office ❑ Kaiser Foundation Hospital ❑ Immunization ❑ Lab Results
❑ Diagnostic Images ❑ Copays & Deductibles ❑ Itemized Billing ❑ Pharmacy
❑ Other (provider, department, specialty): _____

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**

For records from Kaiser Permanente Oregon locations only, Genetic Testing information will not be included unless you check this box ❑

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 _____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Failure to provide all information may invalidate this authorization

Authorization for copies of medical record: ❑ Paper ❑ Electronic

❑ Other: _____ ❑ Inspect or review medical record

Patient Information

Patient name (first, middle, last) (please print): _____

MRN: _____ Date of birth (MM/DD/YYYY): _____ Phone: _____

Street address: _____

City: _____ State: _____ ZIP code: _____

Information to Release to/Request from

I authorize Cedars-Sinai to release/request medical records.

❑ Release to: _____

❑ Request from: _____

Person/Organization: _____

Street address: _____

City: _____ State: _____ ZIP code: _____

Phone: _____ Fax: _____

For the following purpose:

❑ Continuing care ❑ Insurance ❑ Legal

❑ Personal use ❑ Other (please specify): _____

Information to Release

Treatment dates: _____

❑ History and physical report ❑ Radiology report ❑ X-ray film/Images CD

❑ EKG/ECHO ❑ Operative report ❑ Laboratory report

❑ Discharge summary ❑ Consultation report ❑ Emergency record

❑ Pathology report ❑ Billing record

❑ Other (please specify): _____

❑ Outpatient/Clinic record - Clinic/Provider name: _____

Information to Release (continued)

State/Federal laws require specific authorization to release the following types of information:

❑ Mental health ❑ Alcohol/Drug abuse ❑ HIV test results

A separate authorization is required for psychotherapy notes.

Fees

Based on California Evidence Code Sections 1560-1567 Fees may be charged for medical record copies.

Delivery Instructions

❑ Mail records directly to person or organization specified

❑ Call requestor when records are ready for pickup:

I authorize (please print name) _____ to pick up my medical record copies.

Relationship to patient (please print): _____

❑ My CS-Link™ (patient portal)

❑ Email: _____

❑ Other: _____

Notice of Rights

I understand that:

1. If I refuse to sign this authorization my refusal will not affect my ability to obtain treatment.
2. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
3. I may revoke this authorization at any time in writing, **signed by me or on my behalf and delivered to:**
   Cedars-Sinai Medical Center, Health Information Department
   8700 Beverly Blvd., Room 2901
   Los Angeles, CA 90048
4. If I revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation.
5. I have a right to receive a copy of this authorization.

Notice of Rights (continued)

6. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

7. If this ❑ is checked, the requester will receive compensation for the use or disclosure of my information.

Expiration

Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified:

_____

_____

Signature (Patient, Power of Attorney for Healthcare or Legal Representative)

_____ _____

Date (MM/DD/YYYY) Legal representative relationship:

Health Information Management Department
8700 Beverly Blvd., Room 2901, Los Angeles, CA 90048
Email: GroupHIDInternetInquiries@cshs.org
Phone: 310-423-2259 • Fax: 310-423-0113

UCLA Health

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

MRN:
Patient Name:

(Patient Label)

Patient Information	Patient Name: _____MRN: _____ Address: _____ City, State & Zip Code: _____ Date of Birth (MMDDYYYY): _____Phone: (____)_____
Specify Healthcare Facility	☐ UCLA Health Hospitals/Clinics ☐ Jules Stein Eye Institute ☐ Resnick Neuropsychiatric Hospital
Release Records to *Where do you want records sent?* *Who do you want to receive records?*	I authorize **UCLA Health** to release PHI to: Name of Hospital/Clinic/Person: _____ Address: _____ City, State & Zip Code: _____ Phone: (____)_____ FAX: (____)_____ *E-Mail Address: _____ *Note: Please provide your email address to receive an email status of your request. If you would like a designee** to pick up your records, please fill out section below: I authorize _____ to pick up my medical record copies. Relationship to patient: _____ **Note: Designee must provide valid photo ID
Delivery Instructions *(please select one)*	☐ CD ☐ E-Mail (NPH/BHS does not release via email) ☐ Paper Copy ☐ Call Requestor when records are ready for pick up ☐ myUCLAhealth* **Note:** If left blank, a CD will be provided. *See page 2 for myUCLAhealth information
Purpose *What is the purpose of this release?*	☐ At the request of the patient/patient representative ☐ Other (state reason) _____

Health Information to be Released: *What records are being requested?*

Type of Records:

☐ Billing Statements	☐ Emergency Reports (ER)	☐ Pathology Reports
☐ Consultations	☐ History & Physical Exams	☐ Progress Notes
☐ Discharge Summary	☐ Jules Stein Images	☐ Radiology Images (x-rays)
☐ EEG Video	☐ Laboratory Reports	
☐ EKG	☐ Operative Reports	Radiology Reports
☐ Other:		
☐ Mental Health (NPH Psychiatric Hospital & Clinic Records)		

UCLA Health

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

MRN:
Patient Name:

(Patient Label)

Sensitive Information	**Sensitive information will not be released unless specifically authorized below:** ☐ Drug and Alcohol Abuse Results ☐ Genetic Testing Information ☐ HIV/AIDS Test Results ☐ Psychological/Vocational Results
Specify Date/Time Period	SPECIFY DATE / TIME PERIOD FOR INFORMATION SELECTED ABOVE: FROM MM / DD / YYYY TO MM / DD / YYYY
Expiration of Authorization	Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event). If no date is indicated this Authorization will expire 12 months after the date signed.
Signature(s)	_____ _____ (Signature of Patient / Legal Representative) Date _____ _____ Printed Name Area Code/Phone Number If signed by someone other than the patient, indicate relationship to the patient _____ _____ _____ Signature of Witness (only if patient unable to sign) or Interpreter Date Interpreter ID #_____

Mailing Addresses	
☐ Please check box for medical records	☐ Please check box for radiology images
UCLA HIMS, Release of Information 10833 Le Conte Ave, CHS BH-902 Los Angeles, CA 90095-1776 Fax: (310) 983-1468 | Phone: (310) 825-6021 Email: roi@mednet.ucla.edu	**Image Management, Release of Information** 200 Medical Plaza B1- Level | Suite 165-11 Los Angeles CA 90095 Fax 310-825-3205 | Phone 310-825-6425
☐ Please check box for mental health records	**Request medical records via myUCLAhealth** **Visit our website for information:** **https://www.uclahealth.org/medical-records** **Call for Assistance: 855-364-7052**
Mental Health Records RNPH/BHS HIMS 10833 Le Conte Ave BH239A Los Angeles CA 90095 Fax 310-206-7682 Phone 310-267-2661 or 310-794-1530	

Authorization for Release of Health Information

Individual's Full Name	Date of Birth	Member or Subscriber ID #

Individual's Street Address	City	State	Zip Code

I understand and agree that:

- this authorization is voluntary;
- my health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;
- this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying Optum in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Who May Receive and Disclose my Information:

I authorize Optum and its affiliates to disclose my individually identifiable health information to the following person(s) or organization(s):

_____

(Full Name of Person(s) or Organization(s))

_____

(Full Address &/or Phone number of Person(s) or Organization(s))

Type of Information to be Disclosed:

☐ I authorize disclosure of all my health information, including information relating to claims, medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information; **or**

☐ I authorize only the disclosure of the following information:

_____

(Type of Information)

Purpose of Disclosure:

☐ My health information is being disclosed at my request or at the request of my personal representative; **or**

☐ My health information is being disclosed for the following purpose:

_____
(Explain Purpose)

****

_____ _____
Signature of Individual Date

_____ _____
Witness Signature *(For Illinois Residents Only)* Date

Please note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member.

_____ _____
Signature of Individual's Representative Date

Personal Representative's:

_____ _____
Name Phone Number

_____ _____ __ _____
Street Address City State Zip Code

(*For California and Georgia residents only*) I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS

Fax: **866-322-0051**
or
Mail: ATTN Optum ROI Processing
11000 Optum Circle
MN103-0600
Eden Prairie, MN 55344

Main Office
221 North Figueroa Street, Suite 650
Los Angeles, CA 90012

Valley Office
14410 Sylvan Street, 8th Floor
Van Nuys, CA 91401

Behavioral Science Services
Los Angeles Police Department
(213) 486-0790 tel
(213) 482-9517 fax

Authorization

This form when signed by you, the personal representative of the patient when the patient is deceased authorizes Behavioral Science Services to release information from the following patient's file (name of patient) _____. By signing the form you, the personal representative of the patient, assert that you are the official designated representative of the patient as reflected in the Will of the deceased patient or appointed by a court of law. (Please attach a copy of the Will or court documents which clearly specifies that you are the personal representative of the patient when the patient is deceased).

Provide a description of the information that is to be disclosed. Your description should be as specific and detailed as possible.

_____

_____

_____

The information should be released to:

_____

Provide a description for the purpose of the information request by you, the personal representative of the patient.

_____

_____

_____

This authorization shall remain in effect until the following date _____

I understand that I, the personal representative of the patient, have the right to revoke or modify this authorization in writing at any time. However, my revocation or modification will not be effective until BSS receives it.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information. I understand that BSS has no control over how the information is used or disclosed once the information leaves our office.

_____ _____
Signature of personal representative of patient Date

_____
Witness

Behavioral Health Program
Los Angeles Fire Department
201 N. Figueroa St, Suite 1375
Los Angeles, CA 90012

www.lafd.org

(Official Use Only)

Received On: _____

Incident Date: _____

Account Number: _____

RTS Number: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(45 C.F.R. §164.508(c) and 514(h))

Terms and conditions of this authorization - I understand that:

By signing this document I am authorizing Behavioral Health Program to use or disclose my Protected Health Information (PHI), for the purpose stated herein, which may contain personal and medical collected in relation to the medical service(s) provided by Behavioral Health Program of LAFD.

- The person(s)/organization(s) authorized to receive my PHI may not further use or disclose this information without specific written authorization from me or as otherwise specifically required or permitted by law (Cal. Civ. Code § 56.13).
- Unless revoked earlier, this authorization will end on the date/condition/event specified in Section "C" below.
- I may revoke this authorization by providing written notice to the Behavioral Health Program, except to the extent that action has been taken in reliance upon this authorization.
- Behavioral Health Program may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization.

A. Patient Information (All fields in this section are REQUIRED, unless noted otherwise)

Name: _____ Email (optional):_____

Birth Date: _____ SSN _____ / _____ / _____

Phone (Day) _____ (Evening) _____

Address: _____

Street Apt# City State Zip Code

B. Person/Organization authorized to receive the PHI - Please tell us who you are authorizing to receive your PHI by completing the information below. For "Relationship" please provide a general description such as "self", "spouse" or "attorney."

Name (**required**):_____ Relationship (**required**): _____

Phone - Day (**required**) _____ Email: _____

Address (**required**): _____

Street Apt# City State ZIP Code

C. Authorization Duration

- The "Start Date" is the date that this authorization will begin. If “Start Date” is left blank, the date the authorization was signed in Section F will be the “Start Date.”
- The "End Date" is the date that this authorization will end. If “End Date” is left blank, this authorization will remain valid for one (1) year, until the condition set forth below (“Termination Condition/Event”) has been met, or until we receive a written revocation from you.
- The “Termination Condition/Event” will automatically revoke this authorization.

Start Date: _____ End Date: _____ Termination Condition/Event: _____

D. Description of information to be released (please provide a description that is specific and meaningful) - I hereby authorize LAFD Behavioral Health Program to release the following PHI:

Date(s) of Treatment (required): _____

Description (required): ☐ Psychotherapy treatment ☐ Psychotherapy notes ☐ Other_____

E. Purpose for which this release is to be made (NOTE: You are not required to provide a specific purpose; if left blank, Behavioral Health Program will presume the release is simply made at your request.):

_____

F: Signature of Patient, Parent or Guardian, or Personal Representative (All fields are REQUIRED)

Name (Print): _____ Relationship: _____

Signature: _____ Date: _____

By signing this document, I declare under penalty of perjury that all statements contained in this form and accompanying document(s) are true and correct.

****Required Documentation** – All parents, guardians, and personal representatives must submit copies of official documentation evidencing their authority to act on behalf of the patient (e.g. minor’s birth certificate, Medical Power of Attorney or Advance Health Care Directive, court order granting guardianship, marriage or death certificate, etc.). All submitted documents are subject to verification.*

G: Identity Verification (45 C.F.R. § 164.514(h)) – You (the person identified in Section F) must provide:

- A copy of your photo identification which shows your signature (e.g., State Driver’s License, State Identification Card, Passport, Matricula Consular, or City/State/Federal Employment ID Card).

Please return this form and supporting documents to:

Los Angeles Fire Department
Attention: Behavioral Health Program
201 N. Figueroa Street, 1375
Los Angeles, CA 90012

OR

Email: lafd.bhp@lacity.org
FAX (213) 202-5485

If you have questions, or need additional information or assistance in completing this form, please contact us at the above address or call (213) 202-5403

REQUEST PERTAINING TO MILITARY RECORDS

Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/military-service-records/
To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS *(Furnish as much information as possible.)*

1. NAME USED DURING SERVICE (last, first, full middle)	2. SOCIAL SECURITY #	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT *(For an effective records search, it is important that ALL service be shown below.)*

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE	–			☐	☐	
b. RESERVE	–			☐	☐	
c. STATE NATIONAL GUARD	–			☐	☐	

6. IS THIS PERSON DECEASED? ☐ NO ☐ YES - ***MUST*** *provide Date of Death if veteran is deceased:* _____

7. DID THIS PERSON RETIRE FROM MILITARY SERVICE? ☐ NO ☐ YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

☐ **DD Form 214 or equivalent.** Year(s) in which form(s) issued to veteran: _____

This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next-of-kin, or other persons or organizations, if authorized in Section III, below. **An UNDELETED DD214 is ordinarily required to determine eligibility for benefits**. If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost.

An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box: ☐ I want a **DELETED** copy.

☐ **Medical Records** Includes Service Treatment Records, Health (outpatient) and Dental Records. ***IF HOSPITALIZED (inpatient)*** *the FACILITY NAME and DATE (month and year) for EACH admission* ***MUST*** *be provided:* _____

_____

☐ **Other** (Specify): _____

2. PURPOSE: (Providing information about the purpose of the request is **strictly voluntary;** however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

☐ Benefits (explain) ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal ☐ Other (explain)

Explain here: _____

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER NAME: _____

2. ☐ I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section I, above.

☐ I am the DECEASED VETERAN'S NEXT-OF-KIN ***(MUST submit Proof of Death.*** *See item 2a on instruction sheet.)*

_____ –

(Relationship to deceased veteran)

3. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

_____
Name

_____
Street Apt.

_____
City State Zip Code

* This form is available at ***http://www.archives.gov/veterans/military-service-records/standard-form-180.html*** on the National Archives and Records Administration (NARA) web site. *

☐ I am the VETERAN'S LEGAL GUARDIAN ***(MUST submit copy of Court Appointment)*** or AUTHORIZED REPRESENTATIVE ***(MUST submit copy of Authorization Letter or Power of Attorney)***

☐ OTHER

_____
(Specify type of Other)

4. AUTHORIZATION SIGNATURE: I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct and that I authorize the release of the requested information. *(See items 2a or 3a on accompanying instruction sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request if for archival records.)*

_____
Signature Required - Do not print **Date**

_____
Daytime phone Fax Number

_____
Email address

INSTRUCTION AND INFORMATION SHEET FOR SF 180, REQUEST PERTAINING TO MILITARY RECORDS

1. General Information. The Standard Form 180, Request Pertaining to Military Records (SF180) is used to request information from military records. Certain identifying information is necessary to determine the location of an individual's record of military service. Please try to answer each item on the SF 180. If you do not have and cannot obtain the information for an item, show "NA," meaning the information is "not available". Include as much of the requested information as you can. Incomplete information may delay response time. To determine where to mail this request see Page 2 of the SF180 for record locations and facility addresses.

Online requests may be submitted to the National Personnel Records Center (NPRC) by a veteran or deceased veteran's next-of-kin using eVetRecs at http://www.archives.gov/veterans/military-service-records/ .

2. Personnel Records/Military Human Resource Records/Official Military Personnel File (OMPF) and Medical Records/Service Treatment Records (STR). Personnel records of military members who were discharged, retired, or died in service **LESS THAN 62 YEARS AGO** and medical records are in the legal custody of the military service department and are administered in accordance with rules issued by the Department of Defense and the Department of Homeland Security (DHS, Coast Guard). STRs of persons on active duty are generally kept at the local servicing clinic. After the last day of active duty, STRs should be requested from the appropriate address on page 2 of the SF 180. (See item 3, Archival Records, if the military member was discharged, retired or died in service more than 62 years ago.)

a. Release of information: Release of information is subject to restrictions imposed by the military services consistent with Department of Defense regulations, the provisions of the Freedom of Information Act (FOIA) and the Privacy Act of 1974. The service member (either past or present) or the member's legal guardian has access to almost any information contained in that member's own record. The authorization signature of the service member or the member's legal guardian is needed in Section III of the SF180. Others requesting information from military personnel records and/or STRs must have the release authorization in Section III of the SF 180 signed by the member or legal guardian. If the appropriate signature cannot be obtained, only limited types of information can be provided. If the former member is deceased, the surviving next-of-kin may, under certain circumstances, be entitled to greater access to a deceased veteran's records than a member of the general public. The next-of-kin may be any of the following: unremarried surviving spouse, father, mother, son, daughter, sister, or brother. Requesters **MUST provide proof of death**, **such as a copy of a death certificate, newspaper article (obituary) or death notice, coroner's report of death, funeral director's signed statement of death, or verdict of coroner's jury.**

b. Fees for records: There is no charge for most services provided to service members or next-of-kin of deceased veterans. A nominal fee is charged for certain types of service. In most instances, service fees cannot be determined in advance. If your request involves a service fee, you will receive an invoice with your records.

3. Archival Records. Personnel records of military members who were discharged, retired, or died in service **62 OR MORE YEARS AGO** have been transferred to the legal custody of NARA and are referred to as "archival records".

a. Release of Information: Archival records are open to the public. The Privacy Act of 1974 does not apply to archival records, therefore, written authorization from the veteran or next-of-kin is not required. In order to protect the privacy of the veteran, his/her family, and third parties named in the records, the personal privacy exemption of the Freedom of Information Act (5 U.S.C. 552 (b) (6)) may still apply and may preclude the release of some information.

b. Fees for Archival Records: Access to archival records are granted by offering copies of the records for a fee (44 U.S.C. 2116 (c)). If a fee applies to the photocopies of documents in the requested record, you will receive an invoice. Photocopies will be sent after payment is made. For more information see http://www.archives.gov/st-louis/archival-programs/military-personnel-archival/ompf-archival-requests.html.

4. Where reply may be sent. The reply may be sent to the service member or any other address designated by the service member or other authorized requester. If the designated address is NOT registered to the addressee by the U.S. Postal Service (USPS), provide BOTH the addressee's name AND "in care of" (c/o) the name of the person to whom the address is registered on the NAME line in Section III, item 3, on page 1 of the SF 180. The COMPLETE address must be provided, INCLUDING any apartment/suite/unit/lot/space/etc. number.

5. Definitions and abbreviations. DISCHARGED -- the individual has no current military status; SERVICE TREATMENT RECORD (STR) -- The chronology of medical, mental health, and dental care received by service members during the course of their military career (does not include records of treatment while hospitalized); TDRL – Temporary Disability Retired List.

6. Service completed before World War I. National Archives Trust Fund (NATF) forms must be used to request these records. Obtain the forms by e-mail from *inquire@nara.gov* or write to the Code 6 address on page 2 of the SF 180.

PRIVACY ACT OF 1974 COMPLIANCE INFORMATION

The following information is provided in accordance with 5 U.S.C. 552a(e)(3) and applies to this form. Authority for collection of the information is 44 U.S.C. 2907, 3101, and 3103, and Public Law 104-134 (April 26, 1996), as amended in title 31, section 7701. Disclosure of the information is voluntary. If the requested information is not provided, it may delay servicing your inquiry because the facility servicing the service member's record may not have all of the information needed to locate it. The purpose of the information on this form is to assist the facility servicing the records (see the address list) in locating the correct military service record(s) or information to answer your inquiry. This form is then retained as a record of disclosure. The form may also be disclosed to Department of Defense components, the Department of Veterans Affairs, the Department of Homeland Security (DHS, U.S. Coast Guard), or the National Archives and Records Administration when the original custodian of the military health and personnel records transfers all or part of those records to that agency. If the service member was a member of the National Guard, the form may also be disclosed to the Adjutant General of the appropriate state, District of Columbia, or Puerto Rico, where he or she served.

PAPERWORK REDUCTION ACT PUBLIC BURDEN STATEMENT

Public burden reporting for this collection of information is estimated to be five minutes per request, including time for reviewing instructions and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to National Archives and Records Administration (ISSD), 8601 Adelphi Road, College Park, MD 20740-6001. *DO NOT SEND COMPLETED FORMS TO THIS ADDRESS*. SEND COMPLETED FORMS TO THE APPROPRIATE ADDRESS LISTED ON PAGE 2 OF THE SF 180.

The various categories of military service records are described in the chart below. For each category there is a code number which indicates the address at the bottom of the page to which this request should be sent. Please refer to the Instruction and Information Sheet accompanying this form as needed.

BRANCH	CURRENT STATUS OF SERVICE MEMBER	Personnel Record	Medical or Service Treatment Record
AIR FORCE	Discharged, deceased, or retired before 5/1/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 9/30/2004	14	11
	Discharged, deceased, or retired 10/1/2004 – 12/31/2013	1	11
	Discharged, deceased, or retired on or after 1/1/2014	1	13
	Active (including National Guard on active duty in the Air Force), TDRL, or general officers retired with pay	1	
	Reserve, IRR, Retired Reserve in non-pay status, current National Guard officers not on active duty in the Air Force, or National Guard released from active duty in the Air Force	2	
	Current National Guard enlisted not on active duty in the Air Force	2	13
COAST GUARD	Discharge , deceased, or retired before 1/1/1898	6	
	Discharged, deceased, or retired 1/1/1898 – 3/31/1998	14	14
	Discharged, deceased, or retired 4/1/1998 – 9/30/2006	14	11
	Discharged, deceased, or retired 10/1/2006 – 9/30/2013	3	11
	Discharged, deceased, or retired on or after 10/1/2013	3	14
	Active, Reserve, Individual Ready Reserve or TDRL	3	
MARINE CORPS	Discharged, deceased, or retired before 1/1/1895	6	
	Discharged, deceased, or retired 1/1/1905 – 4/30/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 12/31/1998	14	11
	Discharged, deceased, or retired 1/1/1999 - 12/31/2013	4	11
	Discharged, deceased, or retired on or after 1/1/2014	4	8
	Individual Ready Reserve	5	
	Active, Selected Marine Corps Reserve, TDRL	4	
ARMY	Discharged, deceased, or retired before 11/1/1912 (enlisted) or before 7/1/1917 (officer)	6	
	Discharged, deceased, or retired 11/1/1912 – 10/15/1992 (enlisted) or 7/1/1917 – 10/15/1992 (officer)	14	
	Discharged, deceased, or retired 10/16/1992 – 9/30/2002	14	11
	Discharged, deceased, or retired (including TDRL) 10/1/2002 – 12/31/2013	7	11
	Discharged, deceased, or retired (including TDRL) on or after 1/1/2014	7	9
	Current Soldier (Active, Reserve (including Individual Ready Reserve) or National Guard)	7	
NAVY	Discharged, deceased, or retired before 1/1/1886 (enlisted) or before 1/1/1903 (officer)	6	
	Discharged, deceased, or retired 1/1/1886 – 1/30/1994 (enlisted) or 1/1/1903 – 1/30/1994 (officer)	14	14
	Discharged, deceased, or retired 1/31/1994 – 12/31/1994	14	11
	Discharged, deceased, or retired 1/1/1995 – 12/31/2013	10	11
	Discharged, deceased, or retired on or after 1/1/2014	10	8
	Active, Reserve, or TDRL	10	
PHS	Public Health Service - Commissioned Corps officers only	12	

ADDRESS LIST OF CUSTODIANS and SELF-SERVICE WEBSITES (BY CODE NUMBERS SHOWN ABOVE) – Where to write/send this form

1
Air Force Personnel Center
HQ AFPC/DPSIRP
550 C Street West, Suite 19
Randolph AFB, TX 78150-4721

2
Air Reserve Personnel Center
Records Management Branch (DPTSC)
18420 E. Silver Creek Avenue
Building 390 MS 68
Buckley AFB, CO 80011

3
Commander, Personnel Service Center
(BOPS-C-MR) MS7200
US Coast Guard
2703 Martin Luther King Jr Ave SE
Washington, DC 20593-7200
MR_CustomerService@uscg.mil

4
Headquarters U.S. Marine Corps
Manpower Management Records & Performance (MMRP-10)
2008 Elliot Road
Quantico, VA 22134-5030

5
Marine Forces Reserve
2000 Opelousas Avenue
New Orleans, LA 70146-5400

6
National Archives & Records Administration
Research Services (RDT1R)
700 Pennsylvania Avenue NW
Washington, DC 20408-0001

7
US Army Human Resources Command's web page:
https://www.hrc.army.mil/TAGD/Accessing%20or%20Requesting%20Your%20Official%20Military%20Personnel%20File%20Documents
or 1-888-ARMYHRC (1-888-276-9472)

8
Navy Medicine Records Activity (NMRA)
BUMED Detachment St. Louis
4300 Goodfellow Boulevard, Building 103
St. Louis, MO 63120

9
AMEDD Record Processing Center
3370 Nacogdoches Road, Suite 116
San Antonio, TX 78217

10
Navy Personnel Command (PERS-313)
5720 Integrity Drive
Millington, TN 38055-3120

11
Department of Veterans Affairs
Records Management Center
ATTN: Release of Information
P.O. Box 5020
St. Louis, MO 63115-5020

12
Division of Commissioned Corps Officer Support
ATTN: Records Officer
1101 Wooton Parkway, Plaza Level, Suite 100
Rockville, MD 20852

13
AF STR Processing Center
ATTN: Release of Information
3370 Nacogdoches Road, Suite 116
San Antonio, TX 78217

14
National Personnel Records Center
(Military Personnel Records)
1 Archives Drive
St. Louis, MO 63138-1002

***e*VetRecs:**
http://www.archives.gov/veterans/military-service-records/