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| {SFNLogo} | **61324-****{stdMbrPERSLinkID}** |
| **AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION** |
| NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM |
| SFN 61324 (Rev. 08-2021)  **{SFNAddress}** |

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| **PART A MEMBER INFORMATION** | | | | | | |
| Name (Last, First, Middle) {stdMbrFullNameLFM} | | | | | | NDPERS Member ID {stdMbrPERSLinkID} |
| Last Four Digits of Social Security Number {stdMbrLastFourDigitsOfSSN} | | | | | | Date of Birth (mm/dd/yyyy) {stdMbrDateOfBirth} |
| **PART B PLANS**  Select all that apply: | | | | | | |
| Retirement Plan(s)  Defined Benefit  Defined Contribution  457 Deferred Compensation | | Insurance Plan(s)  Life  FlexComp  Health, Dental, Vision (Must also complete an Authorization to Disclose Protected Health Information SFN 58770) | | | | |
| **PART C DISCLOSURE**  I am requesting that my records be disclosed specifically for the following purpose(s): | | | | | | |
|  | | | | | | |
| I authorize NDPERS to disclose the above indicated accounts/records to the following: | | | | | | |
| Agency / Name | | | | | | Relationship (if applicable) |
|  | | | | | |  |
| Address | City | | State | | ZIP Code | Telephone Number |
| **PART E DURATION OF AUTHORIZATION**  Select only one: | | | | | | |
| Specific Date/Event | | | | No Expiration Date | | |
| **PART F AUTHORIZATION**  **I understand I have the right to revoke this authorization in writing at any time by sending written notification to NDPERS by mail, fax or e-mail**. I understand that a revocation is not effective to the extent that NDPERS has already relied on the authorization granted by this form for release or disclosure of confidential information. I understand that information disclosed under this authorization may be further disclosed by the recipient and may no longer be protected by federal or state law. | | | | | | |
| Signature of Member (Electronic Signature will not be accepted) | | | | | | Date |