LACERA Los Angeles County Employees Retirement Association
300 N. Lake Ave., Pasadena, CA 91101 / PO Box 7060, Pasadena, CA 91109-7060 / www.lacera.com / 626/564-6132 • 800/786-6464

AUTHORIZATION TO OBTAIN AND RELEASE RECORDS AND INFORMATION
(SERVICE-CONNECTED DEATH)

REGARDING DECEASED EMPLOYEE: _____

Decedent's Social Security No.: _____ Decedent's Employee No.: _____

Decedent's Kaiser Medical Record No. (if applicable): _____

1. I hereby authorize the Los Angeles County Employees Retirement Association (LACERA) to procure and have in its possession any and all medical and psychological information from the following locations:

2. I understand this includes, but is not limited to, hospital and other records; test results including x-rays, HIV test(s), and lab reports; medical and psychological records, notes, pathology slides, and reports; and records and/or results from any providers of services. This also includes any and all records pertaining to alcohol and/or substance abuse treatment.
3. I hereby authorize LACERA to procure any and all information, including sealed and unsealed documents in the personnel file, payroll, and other records, reports, and/or items concerning the employment of the above-named decedent.
4. I hereby authorize LACERA to procure police and/or other reports concerning any incident in which _____ has been involved.
5. I acknowledge a photocopy of this document shall be as valid as the original.
6. I understand this Authorization shall remain valid until the determination of my request for a survivor allowance.
7. I understand I may receive a copy of this Authorization at any time.
8. I understand I may revoke this Authorization by filing a written revocation with LACERA's Disability Retirement Services. I understand by revoking this Authorization, my Disability Application for a survivor allowance will be subject to rejection.
9. I understand information provided to LACERA may be subject to redisclosure and LACERA cannot guarantee its protection.
10. I understand LACERA is materially relying on the information provided pursuant to this Authorization.

Signature: _____ Date: _____

Print Survivor's Name: _____ Survivor's Social Security No.: _____