United States of America
Railroad Retirement Board

CURRENT

Form Approved
OMB No. 3220-0038

AUTHORIZATION TO DISCLOSE INFORMATION TO THE RAILROAD RETIREMENT BOARD

Whose Records to be Disclosed

Name	Date of Birth
RRB Claim Number	Social Security Number

****PLEASE READ BOTH PAGES OF THE ENTIRE FORM BEFORE SIGNING BELOW IN ITEM B****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF: *All my medical records;* also educational records and other information related to my ability to perform tasks. This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including*, and *not limited to*:
   - Psychological, psychiatric, or other mental impairments (excludes "psychotherapy notes" as defined in 45 CFR 164.501).
   - Drug abuse, alcoholism, or other substance abuse.
   - Sickle cell anemia.
   - Records which may indicate the presence of communicable or non-communicable diseases such as hepatitis, syphilis, or gonorrhea; and tests for or records of HIV/AIDS.
   - Gene-related impairments (including genetic test results).
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Information created within 12 months after the date this authorization is signed, as well as past information.
4. Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.

FROM:

1. All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, VA health care facilities.
2. Social Security Administration.
3. All educational sources (schools, teachers, records administrators, counselors, etc.).
4. Social workers/rehabilitation counselors.
5. Consulting examiners used by the Railroad Retirement Board.
6. Employers, insurance companies, workers' compensation programs.
7. Others who may know about my condition (family, neighbors, friends, public officials).

Name, Address, and Phone Number of Medical Doctor or Institution

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( ) -

TO: The Railroad Retirement Board (RRB) and doctors or other professionals consulted during the process.

PURPOSE: Determining my **eligibility for railroad retirement disability benefits**, including looking at the combined effect of any impairments that by themselves would not meet the RRB's definition of disability.

EXPIRES: This authorization is good for 12 months from the date signed in Item B.1., below.

A. CERTIFICATION

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be re-disclosed to other parties (see the next page for details).
- I may write to the RRB and my sources to revoke this authorization at any time (see the next page for details).
- The RRB will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the type of sources listed.**

B. SIGNATURE (Use Blue or Black Ink Only)

1. **INDIVIDUAL** authorizing disclosure

SIGN ►

If not signed by the subject of the disclosure, specify the basis for your authority to sign

☐ Parent of minor ☐ Guardian
☐ Other personal representative (Explain) _____

Parent/Guardian/Personal representative sign here if two signatures are required by State law

SIGN ►

Date Signed	Street Address		
Telephone Number (with Area Code) ( ) -	City	State	ZIP Code

2. **WITNESS** - **IS NOT REQUIRED BY THE RRB BUT MAY BE BY THE MEDICAL SOURCE**
I know the person signing this form or am satisfied of this person's identity.

SIGN ►

Telephone Number (with Area Code) or Address
( ) -

Second Witness, if needed (e.g., if signed with 'X' above)

SIGN ►

Telephone Number (with Area Code) or Address
( ) -

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191); Title 45 of the Code of Federal Regulations (CFR) parts 160 and 164; Title 42 of the U.S. Code (USC) Section 290dd-2; 42 CFR part 2; 38 USC Section 7332; 38 CFR 1.475; Section 12(n) of the Railroad Unemployment Insurance Act (45 USC Section 362(n)); Section 7(b)(3) of the Railroad Retirement Act (45 USC Section 231f(b)(3)); and State law.

Explanation of Form G-197, Authorization to Disclose information to the Railroad Retirement Board

We need your written authorization to help get the information required to process your claim. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions.

You can provide this authorization by signing a Form G-197. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Railroad Retirement Board (RRB) office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; the RRB can tell you if we identified any sources you didn't tell us about. The RRB may use information disclosed prior to revocation to decide your claim.

Important Information, Including Notice Required By the Privacy Act

All personal information the RRB collects is protected by the Privacy Act of 1974. Once medical information is disclosed to the RRB, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA).

The RRB is authorized to collect the information on Form G-197 by Section 7(b) of the Railroad Retirement Act of 1974. We use the information obtained with this form to determine your eligibility, or continuing eligibility, and for benefits. In some cases, your information may also be reviewed by the RRB personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by the RRB without your consent if authorized by Federal laws such as the Privacy Act. For example, the RRB may disclose information

1. pursuant to law authorizing the release of information from railroad retirement records (e.g., to the Inspector General, to Federal or State benefit agencies or auditors, or to the Department of Veterans Affairs) and
2. to enable a third party (e.g., consulting physicians) or other government agency to assist the RRB to establish rights to railroad retirement benefits and/or coverage.

The RRB will not redisclose without proper prior written consent information: (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2 or (2) regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal Government. The law allows us to do this even if you do not agree to it.

Explanations about possible reasons why information you provide us may be used or given out are available upon request from any RRB office.

Paperwork Reduction Act of 1995

We estimate this form takes an average of 10 minutes per response to complete, including the time needed for reviewing the instructions, getting the needed data, and reviewing the completed form. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing the completion time, to: Chief of Information Resources Management, Railroad Retirement Board, 844 N. Rush Street, Chicago, IL 60611-2092.