# Hospital/Clinic Report

Teachers Retirement System of Georgia

***This form must be filled out if you are applying for Disability Retirement.***

As a member of the Teachers Retirement System of Georgia (TRS), it is your responsibility to obtain the medical information necessary to determine the status of your disability retirement request. Any charges for this information will be at your expense. If you have any questions, please call TRS.

You need to send one of these reports to each hospital and/or clinic where you received treatment and/or diagnosis in the last 12 months.

TRS guarantees the confidentiality of the information provided on this form.

## ▼ To Be Completed by Member -- *please print clearly*

_____ _____ _____ _____
Social Security Number Date of Birth

_____ _____ _____
Last Name First Name Middle Initial

_____
Street Address or P.O. Box

(_____)_____ _____ _____ _____
Telephone Number (daytime) City State Zip Code

_____ _____
Date(s) of Treatment or Diagnosis Date(s) of Discharge

_____ (_____)_____
Name of Institution Institution Phone Number

_____
Address of Institution

_____ _____ _____
City State Zip Code

### Authorization for Release of Medical Information

This is my written authorization to release to the Teachers Retirement System of Georgia any and all medical records and information for the purpose of processing my disability retirement application. This includes any psychiatric/psychological records.

_____ _____
Signature Date

**After completing this section, please forward this report to your hospital/clinic. If you have been treated/diagnosed at more than one hospital/clinic in the last 12 months, you must send a copy of this report to each one.**

## ▼ Instructions to Hospital/Clinic

1. Please send all information requested below that pertains to this patient:

- ✔ Patient History Notes
- ✔ Physical Notes
- ✔ Operative Notes
- ✔ Radiology Reports
- ✔ Lab Reports
- ✔ Pathology Reports
- ✔ Diagnostic Studies
- ✔ Discharge Summary for the Dates of Treatment the patient listed above
- ✔ Surgeon's Report
- ✔ Surgery Records

2. Please include any records regarding treatment or diagnosis for the past 12 months.

3. Please send the requested information directly to TRS at the address listed below. The information you provide is vital in the determination of disability status for this patient.

4. Please bill the person named above for any charges relating to this request. Confidentiality will be maintained. Thank you for your cooperation.

M E D I C A L