



MONTANA TEACHERS' RETIREMENT SYSTEM

1500 E 6TH AVE
PO BOX 200139
HELENA MT 59620-0139
406-444-3134
1-866-600-4045

TRS Office Use Only

AUTHORIZATION FOR RELEASE OF INFORMATION

ALL REQUESTED INFORMATION MUST BE TYPED OR PRINTED LEGIBLY IN DARK INK.

By my signature below, I, (mark one) the member/benefit recipient identified in Part A OR the guardian/attorney-in-fact of the member/benefit recipient identified in Part A, authorize the Teachers' Retirement System of the State of Montana (TRS) to release private information of the member/benefit recipient to the person/entity identified in Part B as set forth under Part C.

Part A: Member/Benefit Recipient

First _____ MI _____ Last _____ X X X - X X - _____
Printed Name Social Security Number

Mailing Address – Including City, State & Zip+4 Code (If unknown, use 5-digit Zip Code)

Area Code and Telephone Number _____ Date of Birth _____

Part B: Person/Entity to Receive Member/Benefit Recipient's Private Information

Printed Name of Person (First, MI, Last)/Entity _____ Relationship _____

Mailing Address – Including City, State & Zip+4 Code (If unknown, use 5-digit Zip Code) Area Code & Telephone Number _____

Part C: Types of Information Authorized to be Disclosed (Select either (a) or (b), but not both.)

a. TRS is authorized to disclose any and all private information pertaining to Member/Benefit Recipient, including but not limited to: information pertaining to past or current employment and/or compensation; eligibility for, elections, or designations related to, or payment of benefits from TRS; and correspondence and other communications with TRS; except that TRS is authorized to disclose the following types of information only if checked:

- Bank Account Information
- Medical Records or Disability Determination Information (Other Than Disability Retirement Status)
- Divorce Decrees/Court Orders Related to a Family Law Order Filed with TRS

b. TRS is authorized to disclose only the following specific information:

Part D: Signature (If signature is of a legal guardian or attorney-in-fact under a Power of Attorney, a copy of a valid Order of Guardianship (except parent of a minor child) or Power of Attorney must be on file with TRS or must be submitted with this Authorization, and the additional information required below must be completed.)

Member/Benefit Recipient, Parent, Legal Guardian, or Attorney-in Fact Signature _____ Date _____

First _____ MI _____ Last _____
Printed Name of Legal Guardian or Attorney-in-Fact

Mailing Address – Including City, State & Zip+4 Code (If unknown, use 5-digit Zip Code) Area Code & Telephone Number _____

Revocation - You may revoke this authorization to disclose private information at any time by providing written notice of revocation to TRS, which notice must include the full name of the Member/Benefit Recipient and the name of the person/entity authorized to receive private information. A revocation of this authorization will not be effective with respect to disclosures already made by TRS in reliance on this authorization. **(PLEASE KEEP A COPY FOR YOUR RECORDS)**

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT OF 1992,
ALTERNATIVE ACCESSIBLE FORMATS OF THIS DOCUMENT WILL BE PROVIDED UPON REQUEST