Printed Name: _____

Soc. Sec. # _____

TO: Any physician or health care provider,
Any hospital, mental health facility, medical clinic, or pharmacy,
Any vocational rehabilitation agency,
The Ohio Public Employees Retirement System ("OPERS"),
The State Teachers Retirement System of Ohio ("STRS"),
The subsidiaries of Unum Group ("Unum"),
The Ohio Bureau of Workers' Compensation,
The Industrial Commission of Ohio.

I hereby authorize you to release to The Ohio State University ("OSU") any and all records and information described in (1) through (4) below:

(1) Records and information about my health, including information concerning my physical and mental condition and medical history, including but not limited to diagnoses, prognoses, treatment, recommendations for treatment, opinions of disability, objective findings and test results, and periods of hospitalization;
(2) Records and information concerning my education, training and experience;
(3) Records and information concerning my employment, including but not limited to dates of employment, compensation, my job description and any employee or union benefits which I am receiving or to which I may be entitled, and
(4) Records or information concerning any benefits which I am receiving or to which I may be entitled, including but not limited to the applications for such benefits.

Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that OSU will use any information it obtains pursuant to this authorization to assist me in my return to work and/or vocational efforts and/or to otherwise assist me in pursuing my claim(s) for benefits. I further understand that information released pursuant to this authorization may no longer be protected under the HIPAA Privacy Rule, but may continue to be protected under other state or federal laws or regulations.

I further hereby authorize OSU to release to any vocational rehabilitation agency, OPERS, STRS, Unum, The Ohio Bureau of Workers' Compensation, and The Industrial Commission of Ohio any and all records and information described in (1) through (4) above. Other than as provided in this authorization, OSU will not further disclose any information it receives without further authorization from me or unless otherwise permitted by law.

I understand and agree that this authorization shall remain valid as long as one of the following is applicable and in effect: [a] I am participating in the a return to work or vocational rehabilitation program with Unum; [b] I have a disability claim with Unum that is pending or active; [ci I have an OPERS disability claim that is pending or active; [d] I have a STRS disability claim that is pending or active; [e] I have a Workers' Compensation claim that is pending or active; or [1] my employment at OSU is in some type of active, leave-of-absence, or disability separation status, or 1 year, which ever is less.

A photocopy of this document shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent OSU has relied on the authorization prior to notice of revocation. I may revoke this authorization by sending written notice to the following address: Unum, The Benefits Center, P.O. Box 100158, Columbia, SC 29202-3158.

_____ _____

Signature Date

If signing on behalf of the individual under a Power of Attorney or Guardian or Conservator relationship, please attach a copy of the document granting authority.

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