

FRANKLIN REGIONAL RETIREMENT SYSTEM

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Authorization for Disclosure of Confidential Retirement and Benefits Information

Complete all sections, date, and sign.

1. I, _____ (print name), hereby voluntarily authorize the Franklin Regional Retirement System to disclose information from my records, and in this specific circumstance, I knowingly waive my right to keep my retirement records confidential. By signing this authorization, I understand that I am releasing the Franklin Regional Retirement System, and its agents, officers, and assignees from any and all potential liability arising out the release of the described records to the person/agency identified below.

2. I am authorizing the release of this information to:

Name of Person/Agency receiving information: _____

Address: _____

Email and phone number: _____

3. The information to be disclosed from my PERS/TRS records (check appropriate box(es)):

Entire Record.

Only information related to (specify): _____

Only the period of events from: _____ to _____

Amount and Effective Date of my current monthly benefit.

Complete payment history.

Disability benefit file.

Other (specify): _____

4. I understand that I may revoke this authorization in writing submitted at any time to the Franklin Regional Retirement System, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will remain in effect unless I have specified a different expiration date or expiration event.

Different expiration date (optional): _____

Different expiration event (optional): _____

I understand that information disclosed by virtue of this authorization may be subject to re-disclosure by the recipient, and that the Franklin Regional Retirement System is not responsible for maintaining the confidentiality of these records once they are released to the recipient.

Signature of Member: _____

Date: _____

Last four numbers of Social Security Number: XXX-XX-_____