CTPF
Chicago Teachers' Pension Fund

Confidential Information Release Authorization

425 S. Financial Place, Suite 1400 | Chicago, IL 60605-1000
312.641.4464 | *Fax* 312.641.7185 | www.ctpf.org

FORM 910
(REV. 11/2019)

MEMBER RECORD TO BE RELEASED

Name: First	M.I.	Last	Last four digits of SSN
Mailing address: Street			Apt. or unit no.
City	State	Zip	Telephone number *(with area code)*
Date of birth			

THIRD PARTY TO RECEIVE INFORMATION

Name: First	M.I.	Last	
Mailing address: Street			Apt. or unit no.
City	State	Zip	Telephone number *(with area code)*
Fax	Email		Relationship to member

INFORMATION TO BE RELEASED

Check One:

- ☐ Entire file, except for information protected by HIPAA
- ☐ Benefit information for divorce or separation proceedings
- ☐ Entire file, except for information protected by HIPAA **and** (specify information that you do not want CTPF to release):

  _____

  _____

  _____

- ☐ The following specific documents:

  _____

  _____

  _____

  _____

  _____

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CERTIFICATION & NOTARIZATION

I understand that certain information contained in the requested CTPF record is confidential and that by signing this Confidential Information Release Authorization, I am waiving this protection to the extent provided for in this form. I hereby authorize CTPF, its employees, and agents to release the requested confidential information to the third-party named in this form. I understand that I may revoke this authorization at any time by giving written notice to the Fund of such revocation, and that such notice is only effective upon actual receipt by the Fund. I understand that if I do not revoke this authorization, it will automatically end 180 days from the date that I sign and date this form.

By signing this form, I certify that the information contained herein is correct. I understand that pursuant to the Illinois Pension Code, 40 ILCS 5/1-135, any person who knowingly makes a false statement or falsifies or permits to be falsified any record in an attempt to defraud the Chicago Teachers' Pension Fund is guilty of a Class 3 felony. I am aware that pursuant to Public Act 97-651, if the CTPF Board has a reasonable suspicion that a false record has been filed with CTPF, it is required to report the matter to the State's Attorney for investigation.

By signing this form, I release and hold harmless CTPF, its agents, and its employees from any and all liability, charges, complaints, claims, causes of action, and damages of any kind which might be asserted in connection with the release of the confidential information described herein.

Name (Member, Agent, or Guardian): _____

Signature *(Member, Agent, or Guardian)*	Date

Notarization:

State of _____ County of _____

On this ___day of _____20_____, _____
personally appeared before me and known to me to be the individual whose name is subscribed as Agent in the foregoing instrument and who executed the foregoing instrument, and he or she acknowledged to me that he or she executed the same, and that the statements contained therein are true.

Notary Signature _____ Expiration Date of Commission ___/___/___

Name of Notary Public and Title _____

(Notary Seal *or* Stamp)