

3. I authorize the following person(s) or organizations to receive my information from the Division of Pensions and Benefits and to use or disclose such information for the purposes listed above. I understand that some or all of the information may no longer be protected by federal privacy standards.

4. Expiration of Authorization. Upon release of the information described above, this authorization request will expire. Any future requests to release and/or disclose protected and private information will require a new Member Authorization Form.

MEMBER'S SIGNATURE

I have had an opportunity to review and understand the contents of this form. I have signed this form voluntarily and confirm that it accurately reflects my wishes regarding the use and/or disclosure of this information.

MEMBER'S SIGNATURE **Date:** ____/____/____
MM / DD / YYYY

If signed by a personal representative, complete the following:

Name of Personal Representative: _____

Relationship to Member or Nature of Authority: _____
(e.g., health care power of attorney, guardian, other legal authorization — A copy of documentation must be attached.):

Address: _____

Daytime Telephone Number: (_____) _____ **E-mail:** _____
AREA CODE

SIGNATURE OF PERSONAL REPRESENTATIVE **Date:** ____/____/____
MM / DD / YYYY

Return to:
Office of Client Services
New Jersey Division of Pensions and Benefits
PO Box 295
Trenton, NJ 08625-0295