United States of America
Railroad Retirement Board

Form Approved
OMB No. 3220-0038

AUTHORIZATION TO DISCLOSE INFORMATION TO THE RAILROAD RETIREMENT BOARD

Whose Records to be Disclosed

Name	Date of Birth
James C Mills	7/25/1971
RRB Claim Number	**Social Security Number**
A 221-52-3482	221-52-3482

****PLEASE READ BOTH PAGES OF THE ENTIRE FORM BEFORE SIGNING BELOW IN ITEM B****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF: *All my medical records*; also educational records and other information related to my ability to perform tasks. This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including*, and *not limited to*:
   - Psychological, psychiatric, or other mental impairments (excludes "psychotherapy notes" as defined in 45 CFR 164.501).
   - Drug abuse, alcoholism, or other substance abuse.
   - Sickle cell anemia.
   - Records which may indicate the presence of communicable or non-communicable diseases such as hepatitis, syphilis, or gonorrhea; and tests for or records of HIV/AIDS.
   - Gene-related impairments (including genetic test results).
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Information created within 12 months after the date this authorization is signed, as well as past information.
4. Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.

FROM:

1. All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, VA health care facilities.
2. Social Security Administration.
3. All educational sources (schools, teachers, records administrators, counselors, etc.).
4. Social workers/rehabilitation counselors.
5. Consulting examiners used by the Railroad Retirement Board.
6. Employers, insurance companies, workers' compensation programs.
7. Others who may know about my condition (family, neighbors, friends, public officials).

Name, Address, and Phone Number of Medical Doctor or Institution

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( ) -

TO: The Railroad Retirement Board (RRB) and doctors or other professionals consulted during the process.

PURPOSE: Determining my **eligibility for railroad retirement disability benefits**, including looking at the combined effect of any impairments that by themselves would not meet the RRB's definition of disability.

EXPIRES: This authorization is good for 12 months from the date signed in Item B.1., below.

A. CERTIFICATION

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be re-disclosed to other parties (see the next page for details).
- I may write to the RRB and my sources to revoke this authorization at any time (see the next page for details).
- The RRB will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the type of sources listed.**

B. SIGNATURE (Use Blue or Black Ink Only)

1. **INDIVIDUAL** authorizing disclosure

X

SIGN ▶

If not signed by the subject of the disclosure, specify the basis for your authority to sign

☐ Parent of minor ☐ Guardian
☐ Other personal representative (Explain) _____

Parent/Guardian/Personal representative sign here if two signatures are required by State law

SIGN ▶

Date Signed	Street Address		
	2406 HUGGINS STREET		
Telephone Number (with Area Code)	**City**	**State**	**ZIP Code**
( ) -	COLUMBUS	GA	31903

2. **WITNESS - IS NOT REQUIRED BY THE RRB BUT MAY BE BY THE MEDICAL SOURCE**
I know the person signing this form or am satisfied of this person's identity.

SIGN ▶

Telephone Number (with Area Code) or Address
( ) -

Second Witness, if needed (e.g., if signed with 'X' above)

SIGN ▶

Telephone Number (with Area Code) or Address
( ) -

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191); Title 45 of the Code of Federal Regulations (CFR) parts 160 and 164; Title 42 of the U.S. Code (USC) Section 290dd-2; 42 CFR part 2; 38 USC Section 7332; 38 CFR 1.475; Section 12(n) of the Railroad Unemployment Insurance Act (45 USC Section 362(n)); Section 7(b)(3) of the Railroad Retirement Act (45 USC Section 231f(b)(3)); and State law.

Explanation of Form G-197, Authorization to Disclose information to the Railroad Retirement Board

We need your written authorization to help get the information required to process your claim. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions.

You can provide this authorization by signing a Form G-197. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Railroad Retirement Board (RRB) office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; the RRB can tell you if we identified any sources you didn't tell us about. The RRB may use information disclosed prior to revocation to decide your claim.

Important Information, Including Notice Required By the Privacy Act

All personal information the RRB collects is protected by the Privacy Act of 1974. Once medical information is disclosed to the RRB, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA).

The RRB is authorized to collect the information on Form G-197 by Section 7(b) of the Railroad Retirement Act of 1974. We use the information obtained with this form to determine your eligibility, or continuing eligibility, and for benefits. In some cases, your information may also be reviewed by the RRB personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by the RRB without your consent if authorized by Federal laws such as the Privacy Act. For example, the RRB may disclose information

1. pursuant to law authorizing the release of information from railroad retirement records (e.g., to the Inspector General, to Federal or State benefit agencies or auditors, or to the Department of Veterans Affairs) and
2. to enable a third party (e.g., consulting physicians) or other government agency to assist the RRB to establish rights to railroad retirement benefits and/or coverage.

The RRB will not redisclose without proper prior written consent information: (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2 or (2) regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal Government. The law allows us to do this even if you do not agree to it.

Explanations about possible reasons why information you provide us may be used or given out are available upon request from any RRB office.

Paperwork Reduction Act of 1995

We estimate this form takes an average of 10 minutes per response to complete, including the time needed for reviewing the instructions, getting the needed data, and reviewing the completed form. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing the completion time, to: Chief of Information Resources Management, Railroad Retirement Board, 844 N. Rush Street, Chicago, IL 60611-1275.

Section 7 Information About Your Work And Earnings

Work for an Employer Last 12 Months

38 Enter an "X" in the appropriate box:
Have you worked and received pay from a railroad or nonrailroad employer in the last 12 months? (Do not include any self-employment.) ▶
☐ Yes ▶ **Go to Item 39**
☐ No ▶ **Go to Item 40**

39 Enter your earnings before any deductions for each month you have already worked ***this year.*** Then starting with the current month, enter your expected gross earnings for this month and each remaining month this year.

January	February	March	April	May	June

July	August	September	October	November	December

Work for an Employer Previous Calendar Year

40 Enter your earnings before any deductions for each month ***last year.***

January	February	March	April	May	June

July	August	September	October	November	December

Work Next 12 Months

41 Enter an "X" in the appropriate box:
Do you expect to work during the next 12 months? (Include self-employment, if any.) ▶
☐ Yes ▶ **Go to Item 42**
☐ No ▶ **Go to Section 8**

42 Enter the name and address of the person or company for whom you expect to work. (If self-employed, enter "Self.") ▶

43 Enter the date(s) you expect to work. (For example: "June and July"; Indefinitely starting 6-16; etc.) ▶

44 Enter the gross amount you expect to earn. (If you are self-employed, enter the **net** amount.) ▶

Section 8 General Information

Filing AA-1

45 Enter an "X" in the appropriate box:
Are you filing Form AA-1 at this time? ▶
☐ Yes ▶ **Go to Item 52**
☐ No ▶ **Go to Item 46**

Self-Employment

46 Enter an "X" in the appropriate box:
Have you been self-employed in the last 12 months? ▶
☐ Yes ▶ **Go to Note and Item 47**
☐ No ▶ **Go to Item 48**

Note: *If answered "Yes," also complete and return to the RRB* ***Form AA-4, Self Employment Questionnaire.***

Section 9 Remarks

Remarks

60 This section is to be used for the continuation of answers to other items. Be sure to include the item number at the beginning of the answer you wish to continue. You may also use this space to enter any additional information that you feel may be important to include.

Section 10 Relinquishment Of Rights By Disability Annuity Applicant Only

I authorize the RRB to relinquish any rights I may have to return to work for a railroad employer, which will affect the payment of my own or my spouse's annuity. Based on this authorization, my rights will be relinquished when I reach full retirement age (FRA) or at age 60-FRA if I become entitled to a supplemental annuity or if my spouse becomes entitled to a spouse's annuity. I understand this authorization remains in effect unless my disability annuity terminates before FRA or before a supplemental or spouse's annuity becomes payable. My rights will also be relinquished if I am eligible for a reduced age and service annuity and choose to receive this type of annuity if my disability is denied.

Section 11 Certification

Certification

61a Did you complete this application with the assistance of an attorney or non-family member (RRB staff excluded)? ▶ ☐ Yes ▶ **Go to Item 61b** ☐ No ▶ **Go to Item 62**

b Enter the name and address of the attorney or non-family member who assisted with completing this application. ▶

c Did you pay a fee to the attorney or non-family member who assisted with completing this application? ▶ ☐ Yes ☐ No

62 Enter an "X" in the appropriate box: Will you have a guardian or other representative sign this application on your behalf? ▶ ☐ Yes ▶ **Go to Note and Item 63** ☐ No ▶ **Go to Item 63**

Note: *If answered* "Yes," the guardian or other representative of the applicant must sign this application. That person must also complete and return ***Form AA-5, Application for Substitution Of Payee.***

63 I certify that the information I gave the Railroad Retirement Board (RRB) on this application is true to the best of my knowledge. I know that if I make a false or fraudulent statement or withhold information in order to receive benefits from the RRB, I am committing a crime under Federal law which may be punishable by fines, imprisonment, or both. I have received and reviewed the booklets, ***RB-1d, Employee Disability Benefits,*** and ***RB-9, Employee and Spouse Annuities Events That Must Be Reported.*** I understand that I am responsible for reporting events that would affect my annuity as explained in the booklets.

I agree to immediately notify the RRB:

- If I work for any employer, railroad or nonrailroad, or perform any self-employment work;
- If my condition improves;
- If I am confined in a jail, prison, penal institution, or correctional facility due to a conviction for a criminal offense;
- If I begin to receive worker's compensation payments (or any other public benefit based on disability), or if the amount of my payment changes;
- If my address changes.
- If I have a claim or a settlement related to my condition(s).

I know that if I am receiving a disability annuity and fail to report work and earnings promptly, I am committing a crime punishable by Federal law that may result in criminal prosecution and/or penalty deductions in my annuity payments.

Signature (First Name, Middle Initial, Last Name) ▶

Date ▶ Month | Day | Year

64 If this certification is signed by mark ("X") in Item 63, two witnesses who know the person signing must sign below, giving their full addresses and daytime telephone numbers.

a. Signature of Witness	b. Signature of Witness
Address (Number and Street)	Address (Number and Street)
City, State/Province, and ZIP Code	City, State/Province, and ZIP Code
Daytime Telephone Number (include area code) ( )	Daytime Telephone Number (include area code) ( )

Section 12 How To Return Your Application

Before you return your application, check to make sure that:

- ***Every*** question that applies to you has been answered.
- You have entered "Unknown" in ***any*** answer space for which you were unable to answer a question.
- You have signed and dated the application.
- You have included ***all*** the needed proofs listed in the letter you received with this application.

When you received your application, you should also have received a pre-addressed return envelope. If you do not have this envelope, you can use any envelope as long as it is addressed to the RRB office shown on page 14. No matter which envelope you use, you must put the correct postage on the envelope. Be careful to provide enough postage, because your application and the accompanying forms may weigh more than a standard letter. The U.S. Postal Service will not deliver your application unless it has the correct postage.

Make one final check before you seal the envelope to ensure that the following are enclosed:

- NEEDED PROOFS
- THE APPLICATION FORM ITSELF
- ADDITIONAL FORMS YOU WERE ASKED TO COMPLETE

Note: *Make no entries on page 14, which is the receipt for your claim. After the RRB receives your application, they will complete the blanks on the receipt and send it back to you. When it is returned to you, you will know that the RRB has received your application and has started the work needed to determine if you are entitled to benefits. If you do not receive the receipt within a month after you filed this application, please contact us so we can find out what is causing the delay.*