

**Manchester Employees' Contributory Retirement System  
AUTHORIZATION TO RELEASE RECORDS**

In connection with my claim for City of Manchester Employees' Contributory Retirement System disability benefits, I hereby authorize any doctor, hospital, clinic, physical therapist, counseling service, rehabilitation center, workers' compensation carrier or administrator, other disability insurance carrier, or any employer to release copies of any and all medical records including, but not limited to, records pertaining to alcohol and substance abuse to the City of Manchester Employees' Contributory Retirement System.

This authorization also allows release of the Department of Labor's file relating to any workers' compensation claim of mine, as well as release of the file maintained by the workers' compensation insurance carrier or administrator with regard to any workers' compensation claim of mine.

I agree to reimburse the said System for its costs associated with the reproduction of the requested documents.

A photocopy of this form as signed by me shall be equivalent to an original.

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Witness: \_\_\_\_\_

**PLEASE FORWARD ALL REQUESTED MATERIAL TO:**

**CITY OF MANCHESTER EMPLOYEES'  
CONTRIBUTORY RETIREMENT SYSTEM  
1045 ELM STREET, SUITE 403  
MANCHESTER, NEW HAMPSHIRE 03101-1824**