

**KENTUCKY PUBLIC PENSIONS AUTHORITY**

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[Print Form](#)

Form 8025
Revised 09/2024

Authorization for Independent Medical or Psychological Examination and Release of Medical Information

Member Information Please provide your Member ID or Social Security Number in the Member ID box below

Member Name:		Member ID:	
KPPA will update contact information for your retirement account based on the details provided below.			
Address:	City:	State:	Zip Code:
Phone (select type) ☐ Mobile ☐ Home ☐ Work		Email:	

Acknowledgment and Authorization

I hereby acknowledge that the Kentucky Public Pensions Authority, or a third-party vendor on its behalf, has recommended an independent medical or psychological examination in accordance with KRS 61.665 and 78.545.

I understand that once the appointment for the independent medical or psychological examination has been made, I will be notified by mail of the date, time, and location of the appointment. Records from the examination will be used in determining my eligibility for disability retirement benefits.

I understand that I am eligible to receive reimbursement for mileage, actual parking costs, and any actual bridge or highway toll charges by filing a completed Form 8846, Travel Voucher for Independent Examination, with all the necessary receipts at the retirement office within fifteen (15) calendar days of the date of the examination or evaluation.

I understand that if I fail or refuse to appear at a scheduled appointment, my claim for disability shall be determined based on the medical information currently contained in my file.

I understand that if I fail to appear, cancel, or reschedule within the time frames required in the appointment notice, I shall be responsible for payment of any charges associated with the medical or psychological examination.

I authorize the Kentucky Public Pensions Authority to release my medical records to the medical or mental health professional who will perform an independent medical or psychological examination for the Kentucky Public Pensions Authority.

Signature: _____

Date: _____

Witnessed: _____

Date: _____