Workers' Compensation Board

WTC HIPAA AUTHORIZATION

World Trade Center Volunteer Health Insurance Portability and Accountability Act Authorization

Patient Name *(use ink only – ballpoint pen, if possible)* **Date of Birth** (MM/DD/YYYY) **Social Security Number**

Mailing Address **City** **State** **Zip**

This authorization form allows the Workers' Compensation Board and the World Trade Center Health Organization to receive copies of health care records containing your protected health information for the purpose of coordinating benefits to you, the World Trade Center volunteer. This form does not allow your health care provider(s) to discuss your health care information with anyone.

This authorization is voluntary. Your health care provider must give you the same care, payment terms, and benefits, whether you sign this form or not. You are entitled to a copy of this authorization.

This authorization expires after the coordination of benefits to you, the WTC volunteer, is complete.

You have the right to revoke this authorization in writing at any time, but a revocation may not be effective if the person or entity authorized has already acted in reliance on this authorization. To revoke this authorization, send a letter to the health care provider(s) listed on this form. In addition, send a copy of this letter to the Workers' Compensation Board.

The information disclosed may be subject to re-disclosure by those receiving it (with the exception of the information below regarding alcohol/drug treatment, HIV/AIDS, mental health treatment and psychotherapy notes), and would no longer be protected by the HIPAA Privacy Rule.

This authorization form does not allow the release of information about alcohol/drug treatment, HIV/AIDS, mental health treatment and psychotherapy notes unless you indicate otherwise, below. Check which information may be released:

☐ Alcohol/Drug Treatment ☐ HIV/AIDS ☐ Mental Health Treatment ☐ Psychotherapy notes

Health care providers who release medical records must follow New York State Law and HIPAA. A copy of this HIPAA-compliant authorization allows your provider to disclose records containing personal health information relating to your current condition, which is the subject of your claim for benefits as a World Trade Center volunteer.

Name of Health Care Provider **Phone Number**

Mailing Address **City** **State** **Zip**

Name of other Health Care Provider (if any) **Phone Number**

Mailing Address **City** **State** **Zip**

I hereby authorize the health care provider(s) listed above to release copies of my health records (only) to the Workers' Compensation Board, the World Trade Center Health Organization, and the September 11th Victim Compensation Fund for the purpose of coordinating benefits to me.

Signature of Patient **Date** (MM/DD/YYYY)

Printed Name

If the patient is unable to sign, the person signing on their behalf must fill out and sign below:

Your Name **Signature** **Relationship to patient** **Date** (MM/DD/YYYY)

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