September 11th
Victim Compensation Fund

Victim's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit B1 to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Pension Records and Health Information by New York Individuals and Entities

Authorization for Release of Pension and Health Information from HIPAA and Non-HIPAA Entities

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that pension and health information be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health provider, pension fund or other entity listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE OR PENSION INFORMATION WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

OMB 1105-0092

Claimant's SSN or National ID Number

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Authorization for Release of Pension and Health Information from HIPAA and Non-HIPAA Entities

7. Name and address of health provider, pension fund, or other entity to release this information: Please indicate all.

- [●] New York Office of Payroll Administration (OPA)
  Room 200N
  One Centre Street
  New York, NY 10007
- [○] New York City Police Pension Fund (POLICE)
  233 Broadway, 19th Floor
  New York, NY 10279
- [○] New York City Fire Pension Fund (FIRE)
  9 MetroTech Center
  Brooklyn, NY 11201
- [○] New York City Employees' Retirement System (NYCERS)
  335 Adams Street, Suite 2300
  Brooklyn, NY 11201-3724
- [○] Teachers' Retirement System of the City of New York (TRS)
  55 Water Street
  New York, NY 10041
- [○] New York City Board of Education Retirement System (BERS)
  65 Court Street, 16th Floor
  Brooklyn, NY 11201-4965
- [○] New York State and Local Retirement System (NYSLRS)
  110 State Street
  Albany, NY 12244-0001

8. Name and address of person(s) or category of person to whom this information will be sent:

September 11th Victim Compensation Fund
P.O. Box 34500
Washington, DC 20043

Overnight deliveries can be made to:

September 11th Victim Compensation Fund
Claims Processing Center
1220 L Street NW
Suite 100 - Box 408
Washington, DC 20005-4018

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9(a). Specific information to be released:

● Complete Pension File, including, but not limited to: Medical records, information regarding the type of pension awarded (ADR, ODR or service), the amount, and whether or not the benefit was awarded pursuant to the WTC Disability Law.

Include: (*Indicate by **Initialing***)

☐ Alcohol/Drug Treatment

☐ Mental Health Information

☐ HIV Related Information

Authorization to Discuss Health or Pension Information

9(b). ● By initialing here ☐, I authorize
(Initials)

The individuals and entities identified in Question #7

(Name of individual health care provider, pension fund or other entity)

to discuss my health or pension-related information with my attorney, or a governmental agency, listed here:

September 11th Victim Compensation Fund and the United States Department of Justice
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:

○ At request of individual

● Other: To evaluate my claim for compensation with the September 11th Victim Compensation Fund

11. Date or event on which this authorization will expire:

Six (6) years from the date of signature or upon my written termination

12. If not the claimant, name of person signing form:

13. Authority to sign on behalf of claimant:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of claimant or representative authorized by law

Date:

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**