



September 11th
Victim Compensation Fund

OMB 1105-0092

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Decedent's SSN or National ID Number

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Personal Representative's SSN or National ID Number

ATTESTATIONS AND CERTIFICATIONS FOR ELIGIBILITY FORM

D. AUTHORIZATION OF RELEASE OF INFORMATION

I Authorize the U.S. Department of Justice to obtain any information relating to my claim under the September 11th Victim Compensation Fund of 2001 (Victim Compensation Fund or VCF) for the purpose of evaluating my claim for compensation to the VCF from individuals, employers, hospitals, medical service providers, other federal, state or local agencies including the Social Security Administration and the Internal Revenue Service, the World Trade Center Health Program (WTCHP), the National Institute for Occupational Safety and Health (NIOSH), the Clinical Centers of Excellence under the WTCHP, the Nationwide Network of health care providers under the WTCHP, the Fire Department of New York, the New York Police Department, the New York Office of Payroll Administration, the New York City Employees' Retirement System, the Teachers' Retirement System of the City of New York, the New York City Police Pension Fund, the New York Fire Department Pension Fund, the New York City Board of Education Retirement System, the New York State Workers' Compensation Board, the State of New Jersey Department of Labor and Workforce Development, Division of Workers' Compensation, the State of Connecticut Department of Social Services, Bureau of Rehabilitation Services (formerly the State of Connecticut Workers' Compensation Commission), the Port Authority of New York and New Jersey, Office of Chief Medical Examiner of the City of New York, New York City Health and Hospitals Corporation, Child Health Plus, Family Health Plus, Medicaid, the WTC Captive Insurance Company, Inc., the Allocation Neutral for the World Trade Center Litigation Settlement, or other sources having information relating to my claim. This information may include, but is not limited to, medical, government, and financial information (including pension records, pension files, or pension information) about me or the Decedent whom I represent. The requested medical information may consist of the Decedent's entire medical records, which may include application or enrollment information, eligibility information, claims records, claim status, patient medical records, patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers. Disclosure requested will include otherwise confidential information. If records include claims or other information pertaining to chronic diseases, behavioral health conditions, including alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information, these records will be included in the information made available to the Victim Compensation Fund.

I Recognize that signing this Authorization is voluntary and that the Decedent's doctors and medical providers and any other entity in possession of Decedent's health information may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. However, the VCF may not be able to evaluate my claim if I do not authorize the release of the Decedent's medical records.

I Further Recognize that health care providers are required by the Privacy Rule under HIPAA to protect the Decedent's health information. When they provide the information to the VCF it will not be protected by this same Privacy Rule. However, the VCF, DOJ and NIOSH will continue to protect the confidentiality of the Decedent's medical records to the extent they are permitted to do so under another federal law, the Privacy Act. The VCF will not disclose the Decedent's identifiable health information that it receives under this Authorization without my written consent except where authorized to do so by law.

I Further Authorize the U.S. Department of Justice to disclose any records or information relating to my Victim Compensation Fund claim for the purpose of determining qualification and/or compensation of my claim to: agency contractors assisting in the administration of the Victim Compensation Fund; other federal, state, or local agencies, including the U.S. Department of Treasury and NIOSH; and other individuals or entities having information related to the claim, such as physicians, medical service providers, insurers, and employers.

I Further Authorize the U.S. Department of Justice to publish the name of the Personal Representative filing a claim and the name of the Decedent for whom compensation is sought.

I Further Authorize the release of information relating to my claim, where such information indicates a violation or potential violation of law, including submission of fraudulent claims, to any civil or criminal law enforcement authority or other appropriate agency charged with responsibility of investigating or prosecuting such a violation.

I Further Authorize individuals, entities, and federal, state and local agencies including NIOSH and the WTCHP, having information pertinent to my claim to release such information to a duly accredited representative of the U.S. Department of Justice during the review of my claim to the Victim Compensation Fund, regardless of any previous agreement to the contrary. Copies of this authorization that show my signature are as valid as the original release signed by me. I acknowledge that I have the right to revoke this Authorization at any time, except to the extent that VCF and the entities listed above have already acted based on this Authorization. I understand that to revoke this authorization, I must write to the VCF at September 11th Victim Compensation Fund, P.O. Box 34500, Washington, D.C. 20043. I recognize that this authorization is valid for six (6) years from the date signed or upon my written termination whichever is sooner.

I Certify that I am the person named below (Personal Representative making a claim to the Victim Compensation Fund on behalf of the Decedent) and I authorize the release of information listed above. I understand that the knowing and willful request for or acquisition of a record pertaining to an individual under false pretenses is a criminal offense subject to a \$5,000 fine.

By initialing, I acknowledge that the information described above may include mental health information and I authorize the release of such information.

Initial here:

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Date (mm/dd/yyyy)

Signature of Personal Representative

Print Name

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