



**September 11th Victim Compensation Fund  
Exhibit A to the Eligibility Form For Personal Injury Claimants  
Authorization for Release of Medical Records**

**Instructions for Claimant** - Please list all doctors and health care providers who were involved in diagnosing and treating your injury, as well as any other entities (e.g., insurance companies, workers' compensation programs, pension programs) that may have medical information in Section 1. Then, please print your name and address and sign in the block in Section 2. Once you have completed and signed this authorization, please make a copy of your signed form and maintain it with your personal records.

**When you sign this document, you give permission to your doctors, health care providers or other entities listed below to disclose your health information to the September 11th Victim Compensation Fund (VCF), the United States Department of Justice (DOJ), and the World Trade Center (WTC) Health Program administered by the National Institute for Occupational Safety and Health (NIOSH)<sup>1</sup> for purposes of evaluating your claim for compensation to the VCF. By signing this document, you also give permission to the VCF to disclose your health information to the WTC Health Program and to the WTC Health Program to disclose your health information to the VCF for the purpose of evaluating your claim for compensation under the VCF.**

Please note that you may revoke this Authorization at any time, except to the extent that the VCF, WTC Health Program, or the providers listed below have already acted based on this Authorization. To revoke this authorization, you must write to the providers or entities listed below and to the VCF at the address at the bottom of page 3 of this form.<sup>2</sup> This authorization is valid for six (6) years from the date signed or upon your written termination, whichever is sooner.

Your doctors and medical providers may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this Authorization. However, the VCF may not be able to evaluate your claim if you do not authorize the release of your medical records. Your decision to sign or not sign this authorization also has no impact on your eligibility for enrollment, monitoring, treatment, or other WTC Health Program benefits.

Your providers and certain other entities are required by the Privacy Rule under HIPAA to protect your health information. When they provide the information to the VCF it will not be protected by this same Privacy Rule. However, the VCF and DOJ will continue to protect the confidentiality of your medical records to the extent they are permitted to do so under another Federal law, the Privacy Act.<sup>3</sup> The VCF will not disclose your identifiable health information that it receives under this Authorization without your written consent except where authorized to do so by law.

**Information to be disclosed by your health care providers (or other entities listed below) to the Victim Compensation Fund includes, but is not limited to, application or enrollment information, eligibility information, claims records, claim status, pension records and files, entire patient medical records, patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to your doctors and medical care providers by other health care providers. Your health care**

<sup>1</sup> For the purposes of this document, all references to the WTC Health Program also include NIOSH to the extent it administers the WTC Health Program.

<sup>2</sup> If you wish to revoke this authorization because you do not want the VCF and WTC Health Program to exchange your health information for purposes of evaluating your claim for compensation under the VCF, then you only need to write to the VCF.

<sup>3</sup> The WTC Health Program will protect your health information pursuant to HIPAA and/or any other relevant laws and regulations.









### 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).**



**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**

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 Fire Department 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

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  
1100 L Street N.W. - Suite 3000  
Washington, DC 20005



**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**

**9(a).** Specific information to be released:

- Complete Pension File, including, but not limited to: 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***)

**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)

Alcohol/Drug Treatment

Mental Health Information

HIV Related Information

<p><b>10. Reason for release of information:</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> At request of individual</li> <li><input checked="" type="radio"/> Other: To evaluate my claim for compensation with the September 11th Victim Compensation Fund</li> </ul>	<p><b>11. Date or event on which this authorization will expire:</b></p> <p>Six (6) years from the date of signature or upon my written termination</p>
<p><b>12. If not the claimant, name of person signing form:</b></p> <p>_____</p>	<p><b>13. Authority to sign on behalf of claimant:</b></p> <p>_____</p>

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.



**September 11th Victim Compensation Fund  
Exhibit B2 to the Eligibility Form For Personal Injury Claimants  
Authorization for Release of Health Information by New York Individuals and Entities**

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA**

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment 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 care provider 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 WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**





**September 11th Victim Compensation Fund  
Exhibit B2 to the Eligibility Form For Personal Injury Claimants  
Authorization for Release of Health Information by New York Individuals and Entities**

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA**

**9(a).** Specific information to be released:

- Medical Record from (insert date) \_\_\_\_\_ to (insert date) \_\_\_\_\_
  - Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.  
Include: (*Indicate by Initialing*)
  - Other: \_\_\_\_\_  
\_\_\_\_\_
- Alcohol/Drug Treatment  
 Mental Health Information  
 HIV Related Information

**Authorization to Discuss Health Information**

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

The individuals and entities identified in Question #7  
\_\_\_\_\_  
(Name of individual health care provider)

to discuss my health 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 patient, name of person signing form:

**13.** Authority to sign on behalf of patient:

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 patient 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.



**September 11th Victim Compensation Fund  
Exhibit C to the Eligibility Form For Personal Injury Claimants  
Attorney Certification of Compliance with Provision on Limitation on Attorney Fees  
(Section 104.81)**

If Claimant has been represented by an attorney for services rendered in connection with this claim,  
**Claimant's attorney must complete the following certification:**

**I hereby certify that:**

- (1) The amount I have charged or will charge for the services I have rendered in connection with this claim, including expenses routinely incurred in the course of providing legal services, is not more than 10 percent of an award that might be paid on this claim; **AND**
- (2) I have not charged nor will I charge for any expenses incurred in connection with this claim that are not routinely incurred in the course of providing legal services, unless the Special Master has approved such expenses; **AND**
- (3) One of the following statements is true concerning a civil action brought by or on behalf of the Claimant for damages sustained as a result of the terrorist-related aircraft crashes of September 11, 2001 or for damages arising from or related to debris removal (excluding civil actions to recover collateral source obligations or against any person who is a knowing participant in any conspiracy to hijack or commit any terrorist act) that was commenced after December 22, 2003 in which a release of all claims in such action was tendered prior to January 2, 2011:
  - I did not charge a legal fee in connection with a settlement of this Claimant's claim(s) in such an action; **OR**
  - I charged a legal fee in connection with a settlement of this Claimant's claim(s) in such an action that was 10 percent or more of the aggregate amount of compensation awarded through such settlement, and I have not charged nor will I charge for any services rendered in connection with this claim with the VCF; **OR**
  - I charged a legal fee in connection with a settlement of this Claimant's claim(s) in such an action that was less than 10 percent of the aggregate amount of compensation awarded through such settlement, and the amount I have charged or will charge for the services I have rendered in connection with this claim with the VCF does not exceed the difference between 10 percent of such aggregate amount and the total amount of all legal fees I charged for services rendered in connection with such settlement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this  day of , 201

Signature of Attorney \_\_\_\_\_

Attorney's Name

Attorney's Firm/Address

Attorney's Firm/Address continued

Suite

City

State

Zip/Postal code

