OMB 1105-0092

Claimant's SSN or National ID Number

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)[1] 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.[2] 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.[3] 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

[1] 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.
[2] 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.
[3] The WTC Health Program will protect your health information pursuant to HIPAA and/or any other relevant laws and regulations.

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providers and/or the VCF may also disclose this information to the WTC Health Program for the purpose of evaluating your claim for benefits under the VCF. In addition, the WTC Health Program may disclose information to the VCF for purposes of evaluating your VCF claim. This information includes, but is not limited to, whether you are a member of the WTC Health Program, and if so, where you receive your WTC Health Program health care benefits; whether you have been certified for treatment under the WTC Health Program; the number of and specific conditions for which you have been certified for treatment under the WTC Health Program; and information relating to payment of claims for treatment and pharmaceuticals received under the WTC Health Program.

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 VCF.

I understand that this authorization is voluntary. However, if you refuse to sign this authorization, the VCF will not be able to process your claim for compensation.

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

I hereby authorize the person, carrier or other entity listed below to disclose confidential information about the claimant listed below to the VCF, the DOJ and NIOSH:

Section 1 - Name, telephone number and email address for doctors, health care providers or other entities.

Physician/Other Entity or Program:

Doctor/Provider/Entity Name

Doctor/Provider/Entity Address

Doctor/Provider/Entity Address continued

Suite Number

City

State/Province

Zip/Postal Code

( ) -

Telephone Number

Email Address

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Section 2 - Claimant information and signature.

Claimant's Last Name

First Name

Middle Name

Mailing Address

Mailing Address continued

Apartment/Suite Number

City

State/Province

Zip/Postal Code

Social Security or National ID Number

Date of Birth (mm/dd/yyyy)

Telephone Number (Home)

Telephone Number (Work)

Telephone Number (Mobile)

Email Address

This information shall be sent to:

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

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Section 2 - Claimant information and signature continued.

I Certify that I am the person named below (Claimant to the Victim Compensation Fund or Authorized Representative of the Claimant) and I authorize the release of information listed above, including disclosure of information by the WTC Health Program to the VCF, for the purposes of evaluating my claim for compensation under the VCF. 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.

Signature of Claimant or Authorized Representative(s)

Date (mm/dd/yyyy)

Print Name

Relationship to Claimant

Type of coverage to which this authorization applies (the doctor, health care provider or other entity will indicate all that apply)

- ◯ Medical
- ◯ Disability
- ◯ Pharmacy
- ◯ Long Term Care
- ◯ Other. Please specify/describe.