September 11th
Victim Compensation Fund

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit A to the Eligibility Form For Deceased Individuals
Authorization for Release of Medical Records

Instructions for Personal Representative - Please list all doctors and health care providers who were involved in diagnosing and treating the Decedent's injury, as well as any other entities (e.g., insurance companies, workers' compensation programs, pension programs) that may have medical information in Section 1. Please copy this exhibit and complete if you need to list more than one health care provider or other entities. Then, please print your name and address and sign in the block in Section 2.

When you sign this document, you give permission to the Decedent's doctors, health care providers or other entities listed below to disclose the Decedent's 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 the Decedent's health information to the WTC Health Program and to the WTC Health Program to disclose the Decedent's 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 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.

The Decedent's providers and certain other entities 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 and DOJ 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.[3] The VCF will not disclose the Decedent's 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 the Decedent's 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 the Decedent's doctors and medical care providers by other health care providers. The Decedent's health care 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 the Decedent's VCF claim.

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[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, as well as all contractors and business associates of NIOSH who conduct activities on behalf of the WTC Health Program, including but not limited to the Clinical Centers of Excellence and Nationwide Provider Network.

[2] If you wish to revoke this authorization because you do not want the VCF and WTC Health Program to exchange the Decedent's 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 the Decedent's health information pursuant to HIPAA and/or any other relevant laws and regulations.

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The Decedent's health care 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 the Decedent was a member of the WTC Health Program, and if so, eligibility and enrollment information; where the Decedent received his/her WTC Health Program health care benefits; whether the Decedent has been certified for treatment under the WTC Health Program; the number of and specific conditions for which the Decedent has 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 Decedent 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. - Decedent information

Decedent's Last Name

First Name

Middle Name

Mailing Address

Mailing Address continued

Apartment/Suite Number

City

State/Province

Zip/Postal Code

Decedent's Social Security or National ID Number

Decedent's Date of Birth (mm/dd/yyyy)

Section 3. - Personal Representative Information and Signature

This information shall be sent to:

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

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.

Personal Representative Signature

Date (mm/dd/yyyy)

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Section 3. - Personal Representative Information and Signature (continued)

Personal Representative'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)

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.