



CLAIMANT'S AUTHORIZATION TO DISCLOSE HEALTH INFORMATION AND WORKERS' COMPENSATION RECORDS

Form with fields: Claimant Name, NYSIF Claim No. and/or WCB Case No., Date of Accident, Date of Birth

I, or my authorized representative, request and authorize that health information regarding my care and treatment, and claims information maintained in workers' compensation records, be released by the New York State Insurance Fund to the person(s) specified in Item 8, below: In accordance with New York State Law, in particular Workers' Compensation Law Sections 98 and 110-a, and Public Officers Law Section 96, I understand that:

- 1. This authorization includes disclosure of information, if any, relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION.
2. The law prohibits the recipient from redisclosing Workers' Compensation Records...
3. I have the right to revoke this authorization at any time...
4. This authorization is valid on a one-time-only basis...
5. Signing this authorization is voluntary...
6. Information disclosed under this authorization might be redisclosed...
7. I UNDERSTAND THAT AN AUTHORIZATION RELEASING WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT IS NOT VALID UNDER SECTION 110-a OF THE WORKERS' COMPENSATION LAW.

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

9. If not the claimant, name of person signing form: 10. Basis of authority to sign on behalf of claimant (e.g., Power of Attorney): Attach documentation of authority.

11. Intended use(s) of records authorized to be released (e.g., litigation, treatment):

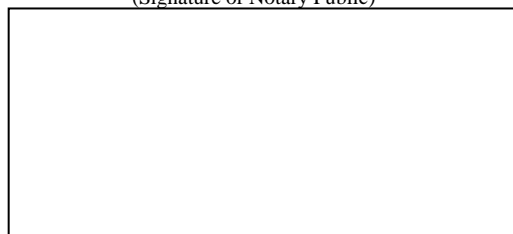
All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form. I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records.

(Signature of claimant or representative authorized by law)

Sworn to before me on this ____ day of _____, 20__

(Signature of Notary Public)

Date: _____



Notary Public Stamp