NYSIF New York State Insurance Fund

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

Claimant Name	NYSIF Claim No. and/or WCB Case No. (one case only)
Date of Accident (one accident only)	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**. In the event the confidential information described below includes any of these types of information, I specifically authorize release of such information to the person(s) indicated in Item 8.
2. The law prohibits the recipient from redisclosing Workers' Compensation Records (including Workers' Compensation Board records), HIV-related, alcohol or drug treatment, or mental health treatment information, (collectively "confidential 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 New York State Insurance Fund. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. This authorization is valid on a one-time-only basis, and shall expire upon the release in response to this authorization of any information to the person(s) indicated in Item 8. I understand that a new authorization shall be required for any subsequent releases.
5. Signing this authorization is voluntary. My treatment, payment, enrollment in a health or insurance plan, or eligibility for benefits will not be conditioned on my authorization of this disclosure.
6. 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.
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.** I affirm that I am not using this authorization to release workers' compensation information to prospective employers or in connection with assessing fitness or capability of employment.

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 copes of these records.

_____

(Signature of claimant or representative authorized by law)

Date: _____

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

_____

(Signature of Notary Public)

Notary Public Stamp