AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION (WTCHP)

Patient Name:_____ Health Record Number:_____

Date of Birth: _____SS#_____

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure:

_____

3. The type and amount of information to be disclosed is limited to records concerning the following illnesses/conditions certified for compensation by the September 11th Victim Compensation Fund_____, or related illnesses/conditions. This is a limited records request intended to minimize the administrative burden, while providing the following information:

- □ Current Diagnosis and severity
- □ Current Medications
- □ Doctor's Notes and Office Visit/Examination Notes or Records (if applicable, limited to time period _____to_____)
- □ Most recent treatment plans
- □ Surgical and Operative Reports and Discharge Reports (if applicable, specify specific surgical procedure_____)
- □ Emergency Department Visits, Admission Records and Discharge Reports
- □ Visits for Acute Episodes related to the disease or condition
- □ Consultation Reports (if applicable, specify type of consultations_____)
- □ Pulmonary Function Tests, Diagnostic Imaging, Diagnostic Summary Reports
- □ Disability Evaluations or Reports
- □ Other_____

4. While not specifically requested, I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by me and to the following individuals or organizations:

_____

Address: _____

City_____ State_____ Zip Code_____

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. I understand that authorizing the disclosure of this health information is voluntary. I understand that I have a right to receive a copy of this request and authorization form. I understand that I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.52. I understand any disclosure or information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact a health insurance representative or medical provider.

8. These records are being sought by myself and my attorneys in relation to a claim I am making to the September 11th Victim Compensation Fund, in which I am a claimant.

_____ _____

Claimant Name Date

_____ _____

If Signed by Legal Representative, Relationship to Patient Signature of Witness

*This authorization is in compliance with the Health Insurance Portability and Accountability act ("HIPAA") 46 CFR 164.52.