NEW YORK STATE OF OPPORTUNITY. | Office of General Services | Business Services Center

Human Resources, Benefits Unit
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Albany, NY 12226-1900
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Phone: 518-457-4272 | Fax: 518-457-1879

WCB Case No. (if you know it):_____

To Claimant: If you received treatment for a previous injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/ illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) states that you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

To Health Care Provider: A copy of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- Voluntary. Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- Limited. It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- Temporary. It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- Revocable. You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. Note: You may not cancel this release with respect to medical records already provided.
- For records only. It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- HIV-related information
- Psychotherapy notes
- Alcohol/Drug treatment
- Mental Health treatment (unless you check below)
- Verbal information (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

A. YOUR INFORMATION (Claimant)

1. Name:_____ 2.Agency:_____

3. Mailing Address: _____

4. Date of Birth: ____/____/____ 5. Date of the current injury/illness: ____/____/____ 6. Social Security Number:_____-_____-_____

7. Current injury/illness, including all body parts injured:_____

_____

8. Your legal representative's name and address (if any): _____

_____

☐ Check here if you allow your health care provider(s) to release mental health care information.

B. YOUR HEALTH CARE PROVIDER(S) (List all health care providers who treated you for a previous injury to the same body part or similar illness. If more than 2 providers, attach their contact information to this form.)

1. Provider:_____ 2. Phone Number: (_____)_____
3. Mailing Address:_____
4. Other provider (if any):_____ 5. Phone Number: (_____)_____
6. Mailing Address:_____

C. READ AND SIGN BELOW.

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

_____
Claimant's signature (ink only) Date

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below:

_____
Your name Relationship to Claimant Signature (ink only) Date