WORKER COMPENSATION INFORMATION

Date_____

PATIENT INFORMATION

Name_____ Birthdate_____ Soc. Sec. #_____

Address_____

_____

Telephone_____ Occupation_____

EMPLOYER

Employer Name_____

Employer Address_____

_____

Employer Telephone_____ Injury Verified By (For Office Use)_____

Contact Person_____

WORKER COMPENSATION CARRIER

Worker Compensation Carrier_____

Carrier Address_____

_____

Carrier Phone Number_____ Coverage Verified by_____

Adjuster's Name_____ Claim Number_____

INJURY INFORMATION

Date of Injury_____ Time_____ ☐ AM ☐ PM

Place of Injury_____

Accident reported to employer? ☐ Yes ☐ No Name of person you reported accident to_____

Give full description of how accident happened_____

_____

_____

_____

_____

Have you lost time from work? ☐ Yes ☐ No How much?_____

Other doctors seen for this condition:

Doctor's Name_____ Diagnosis_____

Were X-Rays taken? ☐ Yes ☐ No Other Tests? ☐ Yes ☐ No

If yes, by whom? Please list test(s) and result(s)_____

_____

_____

_____

Any previous Worker Compensation injuries? ☐ Yes ☐ No Date(s) of previous injuries_____

Describe previous Worker Compensation injuries_____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Workers Compensation benefits is denied.

Patient's Signature_____ Date_____

CLAIMANT'S AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Pursuant to HIPAA)

INSTRUCTIONS
To the Claimant: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) set standards for guaranteeing the privacy of individually identifiable health information and the confidentiality of patient medical records. By completing and signing this form, you authorize your health care provider to file medical reports with the parties that you choose (such as the Workers' Compensation Board, your employer's insurance carrier, your attorney or representative, etc.) by checking the appropriate boxes below.

You have the right to refuse to sign this Authorization. If you sign, you have the right to revoke this Authorization at any time by mailing a request to revoke to the health care provider. You have the right to receive a copy of this Authorization.

IMPORTANT: Failure to execute this authorization may interfere with your ability to obtain workers' compensation benefits.

CLAIMANT'S NAME	CLAIMANT'S SOCIAL SECURITY NUMBER	CLAIMANT'S DATE OF BIRTH

LIST ALL WCB CASE NUMBER(S) AND CORRESPONDING DATE(S) OF ACCIDENT FOR WHICH YOU ARE GRANTING AUTHORIZATION

I, _____, hereby authorize my treating health provider,
Claimant's Name

_____, to disclose the following described health information:
Health Provider's Name

_____

_____

_____

This information can be disclosed to the following parties: *(check all that apply; give names and addresses, if known)*

☐ New York State Workers' Compensation Board

☐ My current/former employer _____

☐ Workers' compensation insurance carrier(s) _____

☐ Third-party administrator _____

☐ My attorney/licensed representative _____

☐ The Uninsured Employer's Fund (this fund is responsible for paying the medical bills and lost wage benefits when an employer is uninsured.)

☐ Special Funds Conservation Committee (for cases under Section 25-a or 15-8 of the Workers' Compensation Law)

Section 25-a: If your claim is being reopened after being previously closed, the Special Fund for Reopened Cases may be responsible for paying your medical bills and lost wage benefits.

Section 15-8: If you had a medical condition that existed prior to this injury, the Special Fund for Second Injuries may be responsible for reimbursing your employer's insurance carrier after a period of time has elapsed.

Redisclosure: I understand that once the above-referenced health care provider discloses health information based on this Authorization, that health information is no longer protected by HIPAA and the Privacy Rule.
Expiration Date: This Authorization expires upon the final closing of the workers' compensation claim(s) for which it is executed.

I have had the opportunity to review and understand the content of this Authorization. By signing this Authorization, I confirm that it accurately reflects my wishes.

_____ _____ _____
Printed Name of Claimant or Legal Representative | Signature of Claimant or Legal Representative | Date

If Authorization signed by a legal representative on behalf of claimant, state relationship to claimant_____and basis for authority (e.g. claimant is a minor; patient is deceased and representative is the claimant in a workers' compensation proceeding or represents the estate) _____

TO THE HEALTH PROVIDER: Keep the original of this Authorization on file. A copy must be given to the patient/claimant upon request.
DO NOT SEND TO THE NEW YORK STATE WORKERS' COMPENSATION BOARD.