NEW YORK STATE | Military and Naval Affairs

Collateral Source Offsets Disclosure 911-F

New York Division of Military and Naval Affairs
330 Old Niskayuna Road
Latham New York 12110-3514

Received Date
DMNA Use Only

Authorization for Release of Pension and Health Information from HIPAA and Non-HIPAA Entities

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that pension and health information be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such 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 (888) 392-3644. This agency is responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health provider, pension fund or other entity listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. 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.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE OR PENSION INFORMATION WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

You must inform DMNA of any collateral source payments you currently receive, or become entitled to receive, after your claim has been filed – including after any award has been determined or paid for the duration of any benefits you are awarded under this program.

For DMNA purposes, collateral source payments are payments that the service member or service member's beneficiaries, receive or are entitled to receive as a result of the victim's injury or death in the terrorist-related aircraft crashes of September 11, 2001 or debris removal in the immediate aftermath of the crashes.

7. Name of health provider, pension fund, or other entity to release this information:

- ☐ September 11th Victim Compensation Fund (VCF)
- ☐ New York Office of Payroll Administration (OPA)
- ☐ New York City Police Pension Fund (POLICE)
- ☐ New York City Fire Pension Fund (FIRE)
- ☐ New York City Employees' Retirement System (NYCERS)
- ☐ Teachers' Retirement System of the City of New York (TRS)
- ☐ New York City Board of Education Retirement System (BERS)
- ☐ New York State and Local Retirement System (NYSLRS)
- ☐ Other _____

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

New York Division of Military and Naval Affairs
Personal and Confidential 911 Claim
330 Old Niskayuna Rd
Latham NY 12110

9(a). Specific information to be released:

☐ Complete Pension File, including, but not limited to: Medical records, information regarding the type of pension awarded, the amount, whether or not the benefit was awarded pursuant to the WTC Disability Law.

Include: (*Indicate by **Initialing***)

☐ Alcohol/Drug Treatment

☐ Mental Health Information

☐ HIV Related Information

Authorization to Discuss Health or Pension Information

9(b). ☐ By initialing here ☐, I authorize

The individuals and/or entities identified in Question #7

(Name of individual health care provider, pension fund or other entity/individual)

to discuss my health or pension-related information with my attorney, or a governmental agency, listed here:

New York State Division of Military and Naval Affairs

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other: To evaluate my claim for compensation with DMNA	**11.** Date or event on which this authorization will expire: Six (6) years from the date of signature or upon my written termination
12. If not the claimant, name of person signing form: _____	**13.** Authority to sign on behalf of claimant: _____

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.

_____ ☐

Signature of claimant or representative authorized by law Date:

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**