



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

Form fields for Patient Name, Date of Birth, Social Security Number, and 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).
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.
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.
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:

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

Please note that the providers listed above may also require similar disclosure of any benefits awarded by DMNA's WTC-BP

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)

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

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.