



**September 11th Victim Compensation Fund
Exhibit A to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Medical Records**

Instructions for Claimant - Please list all doctors and health care providers who were involved in diagnosing and treating your injury, as well as any other entities (e.g., insurance companies, workers' compensation programs, pension programs) that may have medical information in Section 1. Then, please print your name and address and sign in the block in Section 2. Once you have completed and signed this authorization, please make a copy of your signed form and maintain it with your personal records.

When you sign this document, you give permission to your doctors, health care providers or other entities listed below to disclose your health information to the September 11th Victim Compensation Fund (VCF), the United States Department of Justice (DOJ), and the World Trade Center (WTC) Health Program administered by the National Institute for Occupational Safety and Health (NIOSH)¹ for purposes of evaluating your claim for compensation to the VCF. By signing this document, you also give permission to the VCF to disclose your health information to the WTC Health Program and to the WTC Health Program to disclose your health information to the VCF for the purpose of evaluating your claim for compensation under the VCF.

Please note that you may revoke this Authorization at any time, except to the extent that the VCF, WTC Health Program, or the providers listed below have already acted based on this Authorization. To revoke this authorization, you must write to the providers or entities listed below and to the VCF at the address at the bottom of page 3 of this form.² This authorization is valid for six (6) years from the date signed or upon your written termination, whichever is sooner.

Your doctors and medical providers may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this Authorization. However, the VCF may not be able to evaluate your claim if you do not authorize the release of your medical records. Your decision to sign or not sign this authorization also has no impact on your eligibility for enrollment, monitoring, treatment, or other WTC Health Program benefits.

Your providers and certain other entities are required by the Privacy Rule under HIPAA to protect your health information. When they provide the information to the VCF it will not be protected by this same Privacy Rule. However, the VCF and DOJ will continue to protect the confidentiality of your medical records to the extent they are permitted to do so under another Federal law, the Privacy Act.³ The VCF will not disclose your identifiable health information that it receives under this Authorization without your written consent except where authorized to do so by law.

Information to be disclosed by your health care providers (or other entities listed below) to the Victim Compensation Fund includes, but is not limited to, application or enrollment information, eligibility information, claims records, claim status, pension records and files, entire patient medical records, patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to your doctors and medical care providers by other health care providers. Your health care

¹ For the purposes of this document, all references to the WTC Health Program also include NIOSH to the extent it administers the WTC Health Program.

² If you wish to revoke this authorization because you do not want the VCF and WTC Health Program to exchange your health information for purposes of evaluating your claim for compensation under the VCF, then you only need to write to the VCF.

³ The WTC Health Program will protect your health information pursuant to HIPAA and/or any other relevant laws and regulations.



**September 11th Victim Compensation Fund
Exhibit A to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Medical Records**

Section 2 - Claimant information and signature.

[Grid for Claimant's Last Name]

Claimant's Last Name

[Grid for First Name]

First Name

[Grid for Middle Name]

Middle Name

[Grid for Mailing Address]

Mailing Address

[Grid for Mailing Address continued]

Mailing Address continued

[Grid for Apartment/Suite Number]

Apartment/Suite Number

[Grid for City]

City

[Grid for State/Province]

State/Province

[Grid for Zip/Postal Code]

Zip/Postal Code

[Grid for Social Security or National ID Number]

Social Security or National ID Number

[Grid for Date of Birth (mm/dd/yyyy)]

Date of Birth (mm/dd/yyyy)

[Grid for Telephone Number (Home)]

Telephone Number (Home)

[Grid for Telephone Number (Work)]

Telephone Number (Work)

[Grid for Telephone Number (Mobile)]

Telephone Number (Mobile)

[Grid for Email Address]

Email Address

This information shall be sent to:

**September 11th Victim Compensation Fund
P.O. Box 34500
Washington, DC 20043**



September 11th Victim Compensation Fund Exhibit B1 to the Eligibility Form For Personal Injury Claimants Authorization for Release of Pension Records and Health Information by New York Individuals and Entities

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 (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are 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).**



**September 11th Victim Compensation Fund
Exhibit B1 to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Pension Records and Health Information
by New York Individuals and Entities**

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

7. Name and address of health provider, pension fund, or other entity to release this information:
Please indicate all.

- New York Office of Payroll Administration (OPA)
Room 200N
One Centre Street
New York, NY 10007
- New York City Police Pension Fund (POLICE)
233 Broadway, 19th Floor
New York, NY 10279
- New York Fire Department Pension Fund (FIRE)
9 MetroTech Center
Brooklyn, NY 11201
- New York City Employees' Retirement System (NYCERS)
335 Adams Street, Suite 2300
Brooklyn, NY 11201-3724
- Teachers' Retirement System of the City of New York (TRS)
55 Water Street
New York, NY 10041
- New York City Board of Education Retirement System (BERS)
65 Court Street, 16th Floor
Brooklyn, NY 11201-4965

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

September 11th Victim Compensation Fund
P.O. Box 34500
Washington, DC 20043

Overnight deliveries can be made to:

September 11th Victim Compensation Fund
Claims Processing Center
1100 L Street N.W. - Suite 3000
Washington, DC 20005



**September 11th Victim Compensation Fund
Exhibit B1 to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Pension Records and Health Information
by New York Individuals and Entities**

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

9(a). Specific information to be released:

Complete Pension File, including, but not limited to: Information regarding the type of pension awarded (ADR, ODR or service), the amount, and 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
(Initials)

The individuals and entities identified in Question #7

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

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

September 11th Victim Compensation Fund and the United States Department of Justice
(Attorney/Firm Name or Governmental Agency Name)

<p>10. Reason for release of information:</p> <p><input type="radio"/> At request of individual</p> <p><input checked="" type="radio"/> Other: To evaluate my claim for compensation with the September 11th Victim Compensation Fund</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.



Compensation Form Exhibit 1

**Social Security Administration Consent for Release of Information
and
Request for Social Security Earnings Information**

The September 11th Victim Compensation Fund (VCF) will contact the Social Security Administration (SSA) directly to request information that is pertinent to determining your VCF compensation award. In order to request the information from the SSA, this cover page and the two (2) attached forms must be completed, signed, and returned to the VCF. Please carefully follow the instructions below when completing these forms.

Step 1: Write the Claimant or Decedent Name, VCF Claim Number, and Social Security Number in the designated spaces at the bottom of this page.

Step 2: Review the two-page "Social Security Administration Consent for Release of Information" form. To make it easier for you to complete this form, the VCF has already completed many of the required sections. Please fill in the following information on Page 2 of the form:

- Write the Claimant's or Decedent's Name, Date of Birth, and Social Security Number in the spaces at the top of the page.
- Complete the section at the bottom of the page by signing, dating, and providing your daytime phone number.
- If you are not the Claimant (i.e., if you are completing this form as the Personal Representative of a Decedent or as the Authorized Representative of an injured Claimant), please indicate your relationship to the Claimant in the "Relationship" field.

Step 3: Review the four-page "Request for Social Security Earnings Information" form. To make it easier for you to complete this form, the VCF has already completed many of the required sections and has marked certain sections as "Not Applicable". Please fill in the following information on Page 2 of the form:

- Section 1: Write the Claimant's or Decedent's Name, Social Security Number, Other Name(s) Used (if applicable), and Date of Birth in the spaces provided.
- Section 4: Sign, date, and write your daytime phone number.

You do not need to complete any other parts of this form.

Step 4: Upload this page and both signed SSA forms in their entirety to your online claim and select "Exhibit 1: Social Security Administration Form" as the document type. If you filed a hard copy claim, mail the forms to:

September 11th Victim Compensation Fund
PO Box 34500
Washington, DC 20043

***Please do NOT send these forms directly to the Social Security Administration.
Doing so may delay the processing of your VCF claim.***

Claimant or Decedent Full Name: _____

VCF Claim Number: VCF ____ _

Claimant or Decedent Social Security Number: _____

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor, you may complete this form to release only the minor's non-medical records. If you are requesting information for a purpose not directly related to the administration of any program under the Social Security Act, a fee may be charged.

NOTE: Do not use this form to:

- Request us to release the medical records of a minor. Instead, contact your local office by calling 1-800-772-1213 (TTY-1-800-325-0778), or
- Request information about your earnings or employment history. Instead, complete form SSA-7050-F4 at any Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the information applies.
- Fill in the name and address of the individual (or organization) to whom you want us to release your information.
- Indicate the reason you are requesting us to disclose the information.
- Check the box(es) next to the type(s) of information you want us to release including the date ranges, if applicable.
- You, the parent or legal guardian acting on behalf of a minor, or the legal guardian of a legally incompetent adult, must sign and date this form and provide a daytime phone number where you can be reached.
- If you are not the person whose information is requested, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. The information you provide will be used to respond to your request for SSA records information or process your request when we release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent.

We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form in accordance with approved routine uses, which include but are not limited to the following: 1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; 3. To comply with Federal laws requiring the disclosure of the information from our records; and, 4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

*Use This Form If You Need

1. Certified/Non-Certified Detailed Earnings Information

Includes periods of employment or self-employment and the names and addresses of employers.

OR

2. Certified Yearly Totals of Earnings

Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM FOR:

Non-certified yearly totals of earnings

This service is free to the public.

These totals can be obtained by calling 1-800-772-1213 to receive Form SSA-7004, Request for Social Security Statement

PRIVACY ACT NOTICE: We are authorized to collect this information under section 205 of the Social Security Act, and the Federal Records Act of 1950 (64 Stat. 583). It is needed so we can identify your records and prepare the statement you request. You do not have to furnish the information, but failure to do so may prevent your request from being processed.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 11 minutes to read the instructions, gather the facts, and answer the questions. *Send only comments relating to our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

INFORMATION ABOUT YOUR REQUEST

• How Do I Get This Information?

You need to complete the attached form to tell us what information you want.

• Can I Get This Information For Someone Else?

Yes, if you have their written permission. For more information, see page 3.

• Who Can Sign On Behalf Of The Individual?

The parent of a minor child, or the legal guardian of an individual who has been declared legally incompetent, may sign if he/she is acting on behalf of the individual.

• ~~Is There A Fee For This Information?~~

~~1. Certified/Non-Certified Detailed Earnings Information~~

~~Yes, we usually charge a fee for detailed information. In most cases, this information is used for purposes NOT directly related to Social Security such as for a private pension plan or personal injury suit. The fee chart on page 3 gives the amount of the fee.~~

~~Sometimes, there is no charge for detailed information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us~~

~~and it does not agree with your records), we will supply you with more detail for the period in question. Occasionally, earnings amounts are wrong because an employer did not correctly report earnings or earnings are credited to the wrong person. In situations like these, we will send you detailed information, at no charge, so we can correct your record.~~

~~Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.~~

~~We will certify the detailed earnings information for an additional fee of \$15.00. Certification is usually not necessary unless you plan to use the information in court.~~

~~2. Certified Yearly Totals of Earnings~~

~~Yes, there is a fee of \$15 to certify yearly totals of earnings. Certification is usually not necessary unless you plan to use the information in court.~~

~~3. Method of Payment~~

~~Enclose a check or money order for the entire fee required. Payment can also be made by credit card. To do so, complete page 4 of this form and return it with your request form.~~

Not Applicable

Not Applicable

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. From whose record do you need the earnings information?

Print the Name, Social Security Number (SSN), and date of birth below.

Name _____ Social Security Number _____
Other Name(s) Used _____ Date of Birth _____
(Include Maiden Name) (Mo/Day/Yr)

2. What kind of information do you need?

[X] Detailed Earnings Information For the period(s)/year(s): 1998 to present
(If you check this block, tell us below why you need this information.)
It relates to my claim with the Victim Compensation Fund for the purpose of evaluating my claim with the VCF.
[] Certified Yearly Totals of Earnings For the year(s):
(Check this box only if you want the information certified. Otherwise, call 1-800-772-1213 to request Form SSA-7004, Request for Social Security Statement)

3. If you owe us a fee for this detailed earnings information, enter the amount due using the chart on page 3 A. \$ N/A

Do you want us to certify the information? [] Yes [] No
If yes, enter \$15.00 B. \$ N/A

ADD the amounts on lines A and B, and enter the TOTAL amount C. \$ N/A

- You can pay by CREDIT CARD by completing and returning the form on page 4, or
Send your CHECK or MONEY ORDER for the amount on line C with the request and make check or money order payable to "Social Security Administration"
DO NOT SEND CASH.

4. I am the individual to whom the record pertains (or a person who is authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than \$5,000 or one year in prison.

SIGN your name here (Do not print) > _____ Date _____
Daytime Phone Number _____
(Area Code) (Telephone Number)

5. Tell us where you want the information sent. (Please print)

Name U.S. Department of Justice Address September 11th Victim Compensation Fund
City, State & Zip Code P. O. Box 34500, Washington, DC 20043

6. Mail Completed Form(s) To: Exception: If using private contractor (e.g., FedEx) to mail form(s), use:

Social Security Administration Social Security Administration
Division of Earnings Record Operations Division of Earnings Record Operations
P.O. Box 33003 300 N. Greene St.
Baltimore, Maryland 21290-3003 Baltimore, Maryland 21290-0300

Not Applicable

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

How Much Do I Have to Pay For Detailed Earnings?

1. Count the number of years for which you need detailed earnings information. Be sure to add in both the first and last year requested. However, do not add in the current calendar year since this information is not yet available.
2. Use the chart below to determine the correct fee.

Number of Years Requested	Fee	Number of Years Requested	Fee	Number of Years Requested	Fee
1	\$15.00	15	\$ 43.75	28	\$ 64.50
2	17.50	16	45.50	29	66.00
3	20.00	17	47.25	30	67.50
4	22.50	18	49.00	31	68.75
5	25.00	19	50.75	32	70.00
6	27.00	20	52.50	33	71.25
7	29.00	21	54.00	34	72.50
8	31.00	22	55.50	35	73.75
9	33.00	23	57.00	36	75.00
10	35.00	24	58.50	37	76.25
11	36.75	25	60.00	38	77.50
12	38.50	26	61.50	39	78.75
13	40.25	27	63.00	40	80.00
14	42.00				

Not Applicable

For Requests Over 40 Years, Please Add 1 Dollar for Each Additional Year.

• **Whose Earnings Can Be Requested**

1. Your Earnings

You can request earnings information from your own record by completing the attached form; we need your handwritten signature. If you sign with an "X", your mark must be witnessed by two disinterested persons who must sign their name and address.

2. Someone Else's Earnings

You can request earnings information from the record of someone else if that person tells us in writing to give the information to you. This writing or "authorization" must be presented to us within 60 days of the date it was signed by that person.

3. A Deceased Person's Earnings

You can request earnings information from the record of a deceased person if you are the legal representative of the estate, a survivor (that is, the spouse, parent, child, divorced spouse of divorced parent), or an individual with a material interest (example-financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

Proof of death must be included with your request. Proof of appointment as representative or proof of your relationship to the deceased must also be included.

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

As a convenience, we offer you the option to make your payment by credit card. However, regular credit card rules will apply. You may also pay by check or money order.

Please fill in all the information below and return this form along with your request to:

Social Security Administration
Division of Earnings Record Operations
P.O. Box 33003
Baltimore, Maryland 21290-3003

Exception:

If using private contractor (e.g., FedEx) to mail form(s), use:

Social Security Administration
Division of Earnings Record Operations
300 N. Greene St.
Baltimore, Maryland 21290-0300

Note: Please read Paperwork/Privacy Act Notice

CHECK ONE

- Visa American Express
 MasterCard Discover Diners Card

Credit Card Holder's Name
(Enter the name from the credit card)

First Name, Middle Initial, Last Name

Not Applicable

Credit Card Holder's Address

Number & Street

City, State, & Zip Code

Daytime Telephone Number

Area Code

Telephone Number

Credit Card Number

Credit Card Expiration Date

Month

Year

Amount Charged

\$

Credit Card Holder's Signature

**DO NOT WRITE IN THIS SPACE
OFFICE USE ONLY**

Authorization

Name

Date

Remittance Control #

PRIVACY ACT NOTICE

The Social Security Administration (SSA) has authority to collect the information requested on this form under section 205 of the Social Security Act. Giving us this information is voluntary. You do not have to do it. We will need this information only if you choose to make payment by credit card. You do not need to fill out this form if you choose another means of payment (for example, by check or money order).

If you choose the credit card payment option, we will provide the information you give us to the banks handling your credit card account and SSA's account. We may also provide this information to another person or government agency to comply with federal laws requiring the release of information from our records. You can find these and other routine uses of information provided to SSA listed in the Federal Register. If you want more information about this, you may call or write any Social Security Office.