

Limited Release of Health Information (HIPAA)

C-3.3

State of New York - Workers' Compensation Board

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

Insurance
Carrier # _____

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) says 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. Social Security Number: _____

3. Mailing Address: _____

4. Date of Birth: ____/____/____ 5. Date of the current injury/illness: ____/____/____

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

7. 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 -- use blue ballpoint pen, if possible.) _____

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 -- use blue ballpoint pen, if possible.) _____ Date _____

Employee Claim

State of New York - Workers' Compensation Board

C-3

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____
First MI Last
2. Date of Birth: ____/____/____
3. Mailing address: _____
Number and Street/PO Box City State Zip Code
4. Social Security Number: _____ 5. Phone Number: (____) _____
6. Gender: Male Female
7. Will you need a translator if you have to attend a Board hearing? Yes No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____) _____
3. Your work address: _____
Number and Street City State Zip Code
4. Date you were hired: ____/____/____ 5. Your supervisor's name: _____
6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? Yes No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____
2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) Full Time Part Time Seasonal Volunteer Other: _____
4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____
6. Did you receive lodging or tips in addition to your pay? Yes No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: _____ AM PM
3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? Yes No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: _____
First MI Last

DATE OF INJURY/ILLNESS: ____/____/____

D. YOUR INJURY OR ILLNESS continued

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? Yes No If yes, what? _____
9. Was the injury the result of the use or operation of a licensed motor vehicle? Yes No
If yes, your vehicle employer's vehicle other vehicle License plate number (if known): _____
If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____
10. Have you given your employer (or supervisor) notice of injury/illness? Yes No
If yes, notice was given to: _____ orally in writing Date notice given: ____/____/____
11. Did anyone see your injury happen? Yes No Unknown If yes, list names: _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? Yes, on what date? ____/____/____ No, skip to Section F.
2. Have you returned to work? Yes No If yes, on what date? ____/____/____ regular duty limited duty
3. If you have returned to work, who are you working for now? Same employer New employer Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ____/____/____ None received (skip to question F-5)
2. Were you treated on site? Yes No
3. Where did you receive your first off site medical treatment for your injury/illness? none received Emergency Room
 Doctor's office Clinic/Hospital/Urgent Care Hospital Stay over 24 hours
Name and address where you were first treated: _____
Phone Number: (____) _____
4. Are you still being treated for this injury/illness? Yes No
Give the name and address of the doctor(s) treating you for this injury/illness: _____
Phone Number: (____) _____
5. Do you remember having another injury to the same body part or a similar illness? Yes No
If yes, were you treated by a doctor? Yes No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**

6. Was the previous injury/illness work related? Yes No
If yes, were you working for the same employer that you work for now? Yes No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO FRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: ____/____/____

On behalf of Employee: _____ Print Name: _____ Date: ____/____/____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: ____/____/____

Print Name: _____ Title: _____

ID No., if any: R _____ If Licensed Representative, License No.: _____ Expiration Date: ____/____/____