ULTIMATE HEALTH & WELLNESS PC

319 Barrow Street, Jersey City, NJ 07032
bhfordmdpc@gmail.com

Name: txt_name|patientfullname Date: txt_date|ToDay

DOB: txt_dob|DOB

REQUIRED PHARMACY INFORMATION

PREFERRED PHARMACY:

Ultimate Health & Wellness PC -prescribes all medications as mandated by federal laws. In order to comply, we need accurate pharmacy information. All controlled substances must be obtained at the same pharmacy, when possible, and **must** be filled in **The State of NY.**

Should the need to change pharmacies arise, our office must be informed ahead of time. Please provide your pharmacy's information where you expect to fill prescriptions written by the practitioners at the Ultimate Health & Wellness PC.

1. **Pharmacy Name:** _____
2. **Phone:** (_____) _____

   Address: _____ **City :**

   State: _____ Zip _____

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GENERAL CONSENT FOR TREATMENT

I understand by signing this consent, I allow **Ultimate Health & Wellness PC** and their staff to treat me. This includes but not limited to, injections, aspirations, wound care, physical examinations, and receiving prescription medication. **Please be advised that Billy Ford, M.D does not prescribe narcotics and does not routinely complete disability forms.**

Patient Social Security Number: txt_ssn|SSN

Patient Signature: _____

Print Name: txt_name|patientfullname Date: txt_date|ToDay

Guardian (if under 18 years of age):

Signature: _____

Print Name: txt_name|patientfullname

Initial: _____ Date: txt_date|ToDay

For Female Patients Only

I am not pregnant or possibly pregnant. I understand if I become pregnant, it is my full responsibility to notify **Ultimate Health & Wellness PC or Billy Ford, M.D**., or the x-ray technician of such.

Patients Social Security Number: txt_ssn|SSN Date: txt_date|ToDay

Patient Signature: _____ Print Name: _____

Guardian (if under 18 years of age): _____

Signature: _____ Print Name: _____

Date: txt_date|ToDay

Initial _____ Date _____ Initial _____ Date _____

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MEMBER CONSENT FORM

Patient Name: txt_name|patientfullname
Member DOB: txt_dob|DOB
Insurance Carrier: txt_InsCo|InsCo
Subscriber ID#: _____

Dear Provider Claims Processing Department:

This correspondence serves as my official consent for my provider, Dr. Billy Ford, Ultimate Health & Wellness PC, to appeal any type of denial made and/or request additional payment, on my behalf, to my above referenced medical insurance carrier.

I also authorize complete disclosure of my individually identifiable health information, including my plan, policy, and or contract be released by my insurance carrier, and its affiliates, to my named provider Ultimate Health & Wellness PC, in the event it is deemed necessary during any appeals process.

Additionally, I understand and agree that:

- This authorization is voluntary.
- I may not be denied treatment, payment for health care services, enrollment or eligibility for health care benefits if I do not sign this form.
- My health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations.
- . I may revoke this authorization at any time by notifying either my provider or my healthcare provider in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

_____ txt_date|ToDay

Signature of Member Date

Please note: If you are a guardian or court appointed representative, you must attach a *copy of your legal* ***authorization to represent the member and complete the following:***

_____ _____

Guardian or Representative Name Guardian or Representative Signature Date

_____

Guardian or Representative Full Address Guardian or Representative Phone Number

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Financial Agreement Contract

Thank you for trusting **Ultimate Health & Wellness PC,** to partner in your health care. We are committed to providing you with quality, personal health care, and appreciate your commitment to adhere to this Office/ Financial Policy Agreement. By understanding our policy, we can provide you with the best service. Agreement with this policy is required for all medical care. This financial agreement should answer questions regarding patient and insurance responsibility for services rendered. Please read this agreement, ask us any questions you may have, and sign in the space provided. You will be given a copy of this agreement for your records.

Please note that we do not participate with Medicare, Medicaid or any Managed/ Commercial medical insurance plans. We will not be billing any of these insurance plans for services rendered to you unless your plan offers *out of network benefits.*

We would like to advise you that you will be fully responsible for the services rendered if your plan does not offer out of network benefits *unless other arrangements have been made in advance.*

Should you have out of network benefits we will submit a claim for payment, the insurance will make the payment directly to you. You should endorse the check and forward it to our office as soon as possible. You should be aware that there may be a responsibility (coinsurance/deductible) on your part that is not covered by your insurance. The member services department at your insurance carrier may be reached for verification of patient contract details.

** I have read and understand that by signing this Financial Agreement Contract, I fully accept Responsibility for payment of the services provided.

txt_name|patientfullname
Patient , Print Name

Patient Signature

txt_date|ToDay
Date

BILLY FORD, M.D.
Medical Director

ULTIMATE HEALTH & WELLNESS PC
319 Barrow Street, Jersey City, NJ 07032
bhfordmdpc@gmail.com

ASSIGNMENT AND LIEN

Date: txt_date|ToDay

Claimant's Name: txt_name|patientfullname

Date of Accident: txt_doa|DOA

I ("Claimant"), hereby authorize and direct my attorney ("Attorney") to pay directly and in full to **Ultimate Health & Wellness PC and/or Billy Ford, M.D.,** ("Provider") such sums as may be due and owing for medical services rendered by Provider to Claimant by reason of injuries incurred in the subject incident. **This agreement is acting as a valid assignment of Claimant's proceeds from any settlement, judgment, or verdict pertaining to the subject incident;** accordingly, this agreement is not acting as an attempted assignment of the cause of action itself. Such payment shall be drawn from any and all proceeds of any settlement, judgment or verdict that may be paid to Attorney on behalf of Claimant from the cause of action arising from the subject incident. Claimant agrees that this assignment is hereby made a lien against Claimant's claim, and such payment to Provider shall take priority over disbursement of any balance remaining to Claimant.

Provider relies upon the representation of Claimant, that Claimant has elected not to utilize Claimant's health care coverage because Claimant does not want to pay, or does not have the ability to pay, any copayments; and/or that Claimant does not want to meet and pay, or does not have the ability to meet and pay, any required deductible amounts due under the health care coverage; and/or that Claimant does not want to use health care providers within the network of providers available through Claimant health care coverage. Claimant acknowledges and understands that, regardless of whether Claimant proceeds under Claimant's health insurance coverage or through this lien, Claimant will be obligated upon recovery of expenses to pay some consideration for the medical services being provided to Claimant. Claimant affirmatively represents that no person has stated, recommended, counseled, advised or otherwise suggested to Claimant that should not utilize any health insurance coverage for treatment to be rendered to Claimant.

This lien encumbers all insurance coverages available to Claimant, of which insurer is responsible for actual coverage. Claimant authorizes Provider to disclose whatever information is necessary in order to protect and/or perfect the lien rights granted under this agreement.

In the event that other counsel is substituted for the undersigned present counsel, present counsel shall immediately notify the new/incoming counsel of this lien in writing, by certified mail, return receipt requested and shall immediately advise Provider of the name and address of new/incoming counsel in writing, by certified mail, return receipt requested. Claimant agrees and acknowledges that if Claimant changes attorneys, this agreement will remain in force and effect.

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I, the attorney, agree to withhold such sums from any settlement, judgment or verdict from the cause of action arising from the subject incident, and to pay directly and in full to Provider such sums as may be due and owing for medical and related services rendered by Provider to Claimant as a result of the subject incident; and Attorney shall tender payment in full to Provider before disbursing any payment to Claimant.

Claimant and Attorney agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of Provider. However, should any provision of this Agreement be found to be invalid, illegal and unenforceable, or for any reason cease to be binding on any party hereto, all other provisions of this Agreement shall, nevertheless, remain in full force and effect.

Please contact **MDN Billing & Consulting,** 914-376-6100, **melissa@mdnmedicalbilling.com or ncahall@mdnmedicalbilling.com** to arrange for satisfaction of this lien at the time of any resolution, specifically but not limited to any settlement or verdict.

txt_name|patientfullname
Claimant Name (print)

Claimant Signature

txt_date|ToDay
Date

Custodial Parent/Legal Guardian Name (print)

Custodial Parent/Legal Guardian Name (print)

txt_date|ToDay
Date

txt_attorney|Attorney
Attorney Name (print)

Attorney Signature

txt_date|ToDay
Date

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name txt_name|patientfullname	Date of Birth txt_dob|DOB	Social Security Number txt_ssn|SSN
Patient Address txt_addressCityStateZip|fullAddress		

I, or my authorized representative, request that health information regarding my care and treatment 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 care provider 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 WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

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

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

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

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

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.

_____ Date: _____

Signature of patient or representative authorized by law.

* **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.**

NEW YORK STATE | Workers' Compensation Board

PO Box 5205, Binghamton, NY 13902-5205

State of New York
WORKERS' COMPENSATION BOARD

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.

Claimant's Name	Claimant's Social Security No.	Case Number ❑WCB ❑DB ❑Discrimination and/or Date of Accident
txt_name|patientfullname	txt_ssn|SSN	txt_ClaimNumber|Claim txt_doa|DOA

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC CASE NUMBER AND/OR DATE OF ACCIDENT(S).

CLAIMANT IS PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.

INSTRUCTIONS:

Submit original to the Workers' Compensation Board and retain a copy for your records. *Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.* This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, txt_name|patientfullname (Claimant's Name), represent that I am a person who is/was the subject of the Workers' Compensation case(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to _____ (Name of a Specific Person, Corporation, Association or Public or Private Entity), at _____ (Address).

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

_____ txt_date|ToDay

Claimant's Signature (ink only -- use blue ballpoint pen if possible) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

Pursuant to Workers' Compensation Law Section 110-a:

3. Individual authorization. Notwithstanding the restrictions on disclosure set forth under subdivision one of this section, a person who is the subject of a workers' compensation record may authorize the release, re-release or publication of his or her record to a specific person not otherwise authorized to receive such record, by submitting written authorization for such release to the board on a form prescribed by the chair or by a notarized original authorization specifically directing the board to release workers' compensation records to such person. However, in accordance with section one hundred twenty-five of this article, no such authorization directing disclosure of records to a prospective employer shall be valid; nor shall an authorization permitting disclosure of records in connection with assessing fitness or capability for employment be valid, and no disclosure of records shall be made pursuant thereto. It shall be unlawful for any person to consider for the purpose of assessing eligibility for a benefit, or as the basis for an employment-related action, an individual's failure to provide authorization under this subdivision.

4. It shall be unlawful for any person who has obtained copies of board records or individually identifiable information from board records to disclose such information to any person who is not otherwise lawfully entitled to obtain these records.

5. Any person who knowingly and willfully obtains workers' compensation records which contain individually identifiable information under false pretenses or otherwise violates this section shall be guilty of a class A misdemeanor and shall be subject upon conviction, to a fine of not more than one thousand dollars.

6. In addition to or in lieu of any criminal proceeding available under this section, whenever there shall be a violation of this section, application may be made by the attorney general in the name of the people of the state of New York to a court or justice having jurisdiction by a special proceeding to issue an injunction, and upon notice to the defendant of not less than five days, to enjoin and restrain the continuance of such violations; and if it shall appear to the satisfaction of the court or justice that the defendant has, in fact, violated this section, an injunction may be issued by such court or justice, enjoining and restraining any further violation, without requiring proof that any person has, in fact, been injured or damaged thereby. In any such proceeding, the court may make allowances to the attorney general as provided in paragraph six of subdivision (a) of section eighty-three hundred three of the civil practice law and rules, and direct restitution. Whenever the court shall determine that a violation of this section has occurred, the court may impose a civil penalty of not more than five hundred dollars for the first violation, and not more than one thousand dollars for the second or subsequent violation within a three year period. In connection with any such proposed application, the attorney general is authorized to take proof and make a determination of the relevant facts and to issue subpoenas in accordance with the civil practice law and rules.

NEW YORK STATE Workers' Compensation Board

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: txt_fname|FirstName (First) txt_mname|MiddleNar (MI) txt_lname|LastName (Last) 2. Date of Birth: txt_dob|DOB

3. Mailing address: txt_addressCityStateZip|fullAddress (Number and Street/PO Box/Apartment No. / City / State / Zip Code)

4. Social Security Number: txt_ssn|SSN 5. Phone Number: txt_mob|Phone2 6. Gender: txt_sex|Sex

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: txt_doa|DOA 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: txt_fname|FirstN txt_mname|Middl txt_lname|Las **DATE OF INJURY/ILLNESS:** txt_doa|DOA
First MI Last

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 DEFRAUD 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: txt_name|patientfullname Date: txt_date|ToDay

On behalf of Employee: _____ Print Name: txt_name|patientfullname Date: txt_date|ToDa

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: txt_date|ToDay

Print Name: txt_name|patientfullname Title: _____

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

NEW YORK STATE | Workers' Compensation Board

Limited Release of Health Information (HIPAA)

State of New York - Workers' Compensation Board

C-3.3

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

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: txt_name|patientfullname 2. Social Security Number: txt_ssn|SSN
3. Mailing Address: txt_addressCityStateZip|fullAddress
4. Date of Birth: txt_dob|DOB 5. Date of the current injury/illness: txt_doa|DOA
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.

_____ txt_date|ToDay

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:

_____ _____ _____ txt_date|ToDay

Your name | Relationship to Claimant | Signature (ink only -- use blue ballpoint pen, if possible.) | Date

Versión en español al reverso de la forma.

NEW YORK STATE | Workers' Compensation Board

Divulgación limitada de información sobre la salud (HIPAA)

C-3.3

Estado de NuevaYork - Junta de Compensación Obrera (WCB)

WCB Case No. (if you know it) (Número de caso WCB *[si lo sabe])*

Al reclamante: Si usted recibió tratamiento por una lesión anterior en la misma parte del cuerpo o por una enfermedad similar a la que motiva ahora su reclamación, complete este formulario. Este formulario les permite a los proveedores de salud que usted señala a continuación divulgar a la compañía de seguros de compensación obrera de su empleador la información sobre su salud relacionada con su lesión/enfermedad anterior. La Ley federal HIPAA (Ley de portabilidad y responsabilidad del seguro de salud de 1996) establece que usted tiene derecho a recibir una copia de este formulario. Si no comprende este formulario, hable con su representante legal. Si no tiene un representante legal, el Representante de los obreros lesionados de la Junta de Compensación Obrera puede ayudarlo. Llame al 800-580-6665.

Al proveedor de salud: Una **copia** de esta divulgación, redactada según lo que establece la ley HIPAA, le permite divulgar información sobre la salud. Si envía los registros al asegurador de compensación obrera del empleador en respuesta a la presente divulgación, también debe enviar por correo copias al representante legal del reclamante. (Si a continuación no se especifica un representante legal, envíe las copias al reclamante). Los proveedores de salud que divulgan los registros deben cumplir con las leyes del estado de Nueva York y la HIPAA.

Esta divulgación es:

- **Voluntaria.** Su(s) proveedor(es) de salud deben otorgarle la misma atención, condiciones de pago y beneficios, independientemente de que usted firme este formulario o no.
- **Limitada.** Le otorga a su(s) proveedor(es) de salud permiso para divulgar únicamente los registros médicos que se relacionen con la enfermedad/ afección anterior que usted describe a continuación.
- **Temporal.** Termina cuando se otorgue o desestime su actual reclamación de compensación y se hayan agotado todas las apelaciones.
- **Revocable.** Usted puede cancelar esta divulgación en cualquier momento. Para hacerlo, envíe una carta al (a los) proveedor(es) de salud que se indican en este formulario. Además, envíe una copia de su carta a la compañía de seguros de compensación obrera de su empleador y a la Junta de Compensación Obrera. *Nota: No podrá cancelar esta divulgación en lo que se refiere a registros médicos que ya se hayan provisto.*
- **Solamente para registros.** Le otorga a su(s) proveedor(es) de salud que se indica(n) en este formulario permiso para enviar copias de sus registros de salud a la compañía de seguros de compensación obrera de su empleador.

Este formulario NO autoriza a su(s) proveedor(es) de salud a divulgar los siguientes tipos de información:

- **Información relacionada con el VIH**
- **Notas de terapia psicológica**
- **Tratamientos por abuso de alcohol o drogas**
- **Tratamiento de salud mental** (a menos que usted lo indique a continuación)
- **Información verbal** (sus doctores no pueden hablar con nadie sobre su información de salud)

Los registros médicos divulgados se incorporarán a su expediente de compensación obrera y son confidenciales conforme a la Ley de compensación obrera.

CONTESTA LAS SIGUIENTES PREGUNTAS, EN INGLÉS SI ES POSIBLE, EN LOS ESPACIOS PROVISTOS Y FIRMA AL FRENTE DE LA FORMA.

A. YOUR INFORMATION (Claimant) INFORMACIÓN PERSONAL (Reclamante)

1. Name (Nombre)
2. Social Security Number (Número de seguro social)
3. Mailing Address (Dirección postal)
4. Date of Birth (Fecha de nacimiento)
5. Date of the current injury/illness (Fecha de la lesión/enfermedad actual)
6. Current injury/illness, including all body parts injured (Descripción de la lesión/enfermedad actual, incluyendo todas las partes del cuerpo lesionadas)
7. Your legal representative's name and address (if any) (Nombre y dirección de su representante legal [si corresponde])

*Check here if you allow your health provider(s) to release **mental health care** information. (Marque aquí si autoriza a su(s) proveedor(es) de salud a divulgar información sobre **tratamientos de salud mental**.)*

B. YOUR HEALTH CARE PROVIDERS (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.

SU(S) PROVEEDOR(ES) DE SALUD (Enumere todos los proveedores de salud que le han tratado por lesiones previas a las mismas areas del cuerpo ó por enfermedades semejantes.Si son más de 2 proveedores, adjunte su información de contacto a este formulario.)

1. Provider (Proveedor de salud)
2. Phone Number (Nº de teléfono)
3. Mailing Address (Dirección postal)
4. Other provider (if any) (Otro proveedor [si corresponde])
5. Phone Number (Nº de teléfono)
6. Mailing Adress (Dirección postal)

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. **LEA Y FIRME A CONTINUACIÓN.** Por la presente solicito que los proveedores de salud aquí enumerados le provean al asegurador de compensación obrera de mi patrono copias de todos los records médicos relacionados a cualquier lesión/enfermedad aquí enumeradas.

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below: (**Si el reclamante no puede firmar**, la persona que firme el formulario en su nombre y representación debe llenar y firmar a continuación)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Claimant's signature (Firma del reclamante) use solo tinta - preferiblemente azul — Date (Fecha)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Your name (Su nombre) — Relationship to Claimant (Relación con el reclamante) — Signature(Firma) — Date(Fecha)