

**AUTHORIZATION TO OBTAIN INFORMATION**

**AUTHORIZATION FOR THE USE AND DISCLOSURE  
OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION**

**I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize Warren County Self-Insurance to receive may be re-disclosed and no longer protected by federal privacy regulations.**

1. Person(s) / organizations authorized to use or disclose the information:

Any medical facility that has treated me in the past.

2. Person(s) / organization to whom the requested use or disclosure may be made:

Warren County Self-Insurance and/or its agents.

3. Specific description of information that may be used or disclosed:

Copies of medical records including, but not limited to, patient questionnaires, patient intake sheets, referral forms, patient history forms, office notes, reports, charts, x-ray or other films, etc., and/or copies of hospital and medical records relating to services rendered to me for the following medical condition(s):

Any condition except those excluded below.

Excluding (1) any and all confidential HIV and AIDS related information protected under Article 27-F of the New York Public Health Law and (2) any and all confidential mental health records protected under Section 33.13 of the New York Mental Hygiene Law.

4. Purpose of the requested use or disclosure:

For the use in a pending Workers' Compensation claim brought by me.

5. I understand that I may revoke this authorization at any time by giving written notice to the person / organization that is providing the information I no longer want to be used or disclosed, except to the extent that action has already been taken in reliance on this authorization.

6. I understand that the medical provider may not condition the provision of health care services on whether I sign this authorization.

7. This authorization expires upon the final closure of the Workers' Compensation claim brought by the individual.

8. Photocopies of this authorization should be accepted as original.

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Signature of Individual Authorizing Use/Disclosure      Date      Printed Name of Individual

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For Office Use: Date of Injury: \_\_\_\_\_ Carrier Case # \_\_\_\_\_ WCB# \_\_\_\_\_