# Cross Bay Physical Medicine and Rehabilitation, P.C.
# Cross Bay Foot Care Center
# Cross Bay Physical Therapy

(Please Print)

| Today's date: | PCP: |
|---|---|

## PATIENT INFORMATION

| Last name: First: Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid | |
|---|---|---|---|---|
| E-mail : | SSN #: | Birth date: / / | Age: | Sex: ❑ M ❑ F |
| Street address: Apt.# | Home ph.# ( ) | Cell ph#( ) | | |
| P.O. box: | City: | State: | ZIP Code: | |
| Occupation: | Employer: | Employer ph# ( ) | | |
| Whom may we thank for referring you? | | | | |

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Insurance:

| Subscriber's/Policy Holder name: | Subscriber's SSN #: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $ |
|---|---|---|---|---|---|
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other | |

Secondary Insurance :

| Subscriber's/Policy Holder name: | Subscriber's SSN #: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $ |
|---|---|---|---|---|---|
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other | |

## IN CASE OF EMERGENCY

| Name : | Relationship to patient: | Home Phone # ( ) | Work Phone# ( ) |
|---|---|---|---|

## INSURANCE ASSIGMENT AND RELEASE

I certify that I have insurance coverage with ______________________________________________ and assign directly to **Dr. Benjamin Bieber / Dr. Debra Weinstock** (circle one) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above named doctor may use my health care information and may disclose such information to the above named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

## MEDICARE/MEDICAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits be made on my behalf to **Dr. Benjamin Bieber / Dr. Debra Weinstock** (circle one) for any services furnished to me by that provider.
To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medicap insurer and their agents any information needed to determine these benefits for related services.

### SIGNATURE OF BENEFICIARY, GUARDIAN OR PERSONAL REPRESENTATIVE

| ___________________________________ | ___________________________________ | _________________________ | ________________ |
|---|---|---|---|
| Print Name | Signature of Patient or Responsible party | Relationship to Beneficiary | Date |

entered by_________reviewed by____________Date:____________ *Updated: 2/13*

Cross Bay Physical Medicine and Rehabilitation, P.C.
Cross Bay Foot Care Center
Cross Bay Physical Therapy

# *Confidential* MEDICAL HISTORY FORM

**Name** ____________________ **Birthdate** ___ ____________**Date** __________

**Chief Complaint:**________________________________________

**History of Chief Complaint**________________________________________

**List any allergies you have to drugs, food or other items:**

Allergy......................................Reaction

____________________ ____________________

____________________ ____________________

**List the medications you are now taking:**

| Medication | Dose | Frequency | | Medication | Dose | Frequency | |
|---|---|---|---|---|---|---|---|
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Do you: Smoke? ____________packs per day______________# years smoked_____

When did you quit? ________ Work Status? ______________

**Primary Care Physician**:

**Name:**________________________________________

**Address/Phone:**________________________________________

It is the **patient's responsibility** to inform the office about *any changes* **in your insurance**, address or telephone number. You are responsible to bring all appropriate insurance referrals & authorizations, if such required**. Failure to do so will result in financial responsibility for the services provided**

Signature: ________________________________Date:____________________

entered by_________reviewed by____________Date:____________ *Updated: 2/13*

## *Confidential* MEDICAL HISTORY FORM (continued)

| Condition | Yes | No | Note |
|---|---|---|---|
| **Recent Fever** | | | |
| **Weight loss** | | | |
| **Infection** | | | |
| **Cancer type:** | | | |
| **Skin Condition** | | | |
| Athlete's foot | | | |
| Psoriasis | | | |
| Skin cancer | | | |
| **Hearing loss, Ear condition, Eye condition,Throat problems** | | | |
| **Heart/ Vascular conditions** | | | |
| Heart attack | | | |
| Heart disease | | | |
| Congestive heart Failure | | | |
| Heart murmur,mitral valve prolapse | | | |
| Phlebitis | | | |
| Poor circulation | | | |
| Bleeding condition | | | |
| High blood pressure | | | |
| Vascular disease | | | |
| **Breathing problems** | | | |
| Asthma, emphysema, bronchitis tuberculosis | | | |
| **Stomach/ Intestinal** | | | |
| Liver ulcers | | | |
| Diverticlosis, colitis, bowel disease,liver disease, jaundice, hepatitis | | | |
| **Prostrate problems** | | | |
| **Problems with muscles, joints, or bones** | | | |
| Arthritis | | | |
| Back problems | | | |
| Neck problems | | | |
| Shoulder problems | | | |
| Elbow problems | | | |
| Wrist problems | | | |
| Hip problems | | | |
| Knee problems | | | |
| Ankle problems | | | |
| Foot problems | | | |
| Joint aches | | | |
| Weakness | | | |
| Malaise | | | |
| **Rheumatology** | | | |
| Fibromyalgia | | | |
| Gout | | | |
| Lupus | | | |
| Lyme disease | | | |

SIGNATURE: X_______________________________ DATE:____________________________

entered by_________reviewed by____________Date:____________

# *Confidential* MEDICAL HISTORY FORM (continued)

| | | | |
|---|---|---|---|
| Polymyalgia rheumatica | | | |
| Polymyositis | | | |
| Psoriatic arthritis | | | |
| Raynaud's syndrome | | | |
| Reitor's syndrome | | | |
| Rheumatoid arthritis | | | |
| Scleroderma | | | |
| Sojourn's Disease | | | |
| Spinal stenosis | | | |
| **Endocrine system problems** | | | |
| Diabetes | | | |
| Thyroid problems | | | |
| Pancreas problems | | | |
| **Neurology problems** | | | |
| Nerve problem- Numbness | | | |
| Neuropathy- Radiculopathy | | | |
| Stroke | | | |
| Unstable Walking | | | |
| Falls- Falling | | | |
| Walk with cane or walker | | | |
| **Psychological problems Depression** | | | |

*List all operations:*

Operation Performed Year Hospital Doctor

__________________ ________ _________________ ___________________

__________________ ________ _________________ ___________________

**Please check if any relative (parents, siblings, grandparents, children) have had any of the conditions listed below:**

High blood pressure: ____ Kidney Disease:____ Asthma:____ Stroke:____ Cancer:____
Bleeding Tendencies____ Tuberculosis:____Seizures:____ Colitis:____Gout:____
Emphysema: ____ Heart Disease: ____Anemia:____Ulcers:____ Mental Illness:____
Sugar Diabetes: ____ other serious Illness: _________________________________

**Vital Signs by History:**

Blood Pressure________Date_________Height_________Date_________Weight_________Date___________

**Please list the date and results (if Known) of your last:**
X-Ray/ MRI: ___________________________

**Treatment Consent:**
I hereby consent and give my permission to the doctor (doctor's assistant or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Signature of Patient, Guardian or Personal Representative X________________________________________

Date:________________________________________

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## Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

___________________________ _______________
Patient Name (Please Print) Date

____________________________________________
Parent or Authorized Representative (if applicable)

___________________________
Signature

## Insurance Certification

Date: ___________________________________

Patient Name: ___________________________________
PRINT NAME

All patients are responsible to inform their health care provider if their injuries are either work-related or due to a care accident.

Is this visit due to a work-related injury? Yes No

Is this visit related to a car accident? Yes No

Injury Sites: ______________________________________________________________

______________________________________________________________________

***** IMPORTANT INFORMATION*****

IF YOUR CASE IS WORK RELATED OR AN AUTO ACCIDENT THEN PLEASE NOTIFY OUR OFFICE WHEN YOUR INSURANCE COMPANY SEDNS YOU FOR AN INDEPENDENT MEDICAL EXAMINATION (IME).

**FAILURE TO NOTIFY OUR OFFICE OF THIS APPOINTMENT, ANY VISITS ATTENDED AFTER THE IME WILL BECOME PATIENT RESPONSIBILITY!**

I certify that the above statements are true.

X_____________________________________ _______________
*Signature of Patient or Responsible party* *Date:*

entered by_________reviewed by____________Date:____________ *Updated: 2/13*

Cross Bay Physical Medicine and Rehabilitation, P.C.
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## Our Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

All patients must complete our information and insurance form before seeing the doctor. We accept cash, checks, Visa, MasterCard and Discover.

Regarding insurance...

We accept assignment of insurance under most plans. We cannot bill your insurance unless you give us your insurance information and an original claim form if necessary. Your insurance policy is a contract between you and your insurance company. We are not party to the contract. Please be aware that some, and perhaps all, of the services provided may be non- covered services not considered reasonable and necessary under the Medicare Program and/ or other medical insurance. The balance due is your responsibility whether your insurance company pays or not.

Usual and Customary rates...

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult patients...

Adult patients are responsible for full payment at time of service.

Minor Patients...

The accompanying adult of minor and /or the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non- emergency treatment will be denied unless payment by cash or check at time of service has been verified.

X_________________________ Date____________________
*Signature of patient or responsible party*

X_______________________________ Date____________________
*Signature of co- responsible party*

# Prescription Agreement Form

The purpose of this agreement is to protect your access to controlled substances and protect our ability to prescribe for you.
The long- term use of such substances as opiods (narotics, analgesics), benzodiazepine tranquilizers and barbiturate sedatives is controversial because of uncertainty regarding, the extent to which they provide-long term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of the risk is not certain.
Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial or continued prescription of a con trolled substance to treat your chronic pain.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:
   ________________________________ Phone: ________________________
3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacist or other professionals who provide your health care for purposes of maintaining accountability.
5. You may not share, sell or otherwise permit others to have access to these medications.
6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.
8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or other wise have access to them.

X______________________________________ Date________________________
*Signature of patient or responsible party*

WORKERS' COMPENSATION BOARD
New York State

# Employee Claim

**C-3**

***State of New York - Workers' Compensation Board***

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: ________________________________ 2. Date of Birth: ____/____/____
First MI Last

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): ____________________



THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

**YOUR NAME:**________________________________________ **DATE OF INJURY/ILLNESS:** _____/_____/_____
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: ______________________________ 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: _____/_____/_____

WORKERS' COMPENSATION BOARD
New York State

# 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:_________________________ 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



Versión en español al reverso de la forma.

WORKERS' COMPENSATION BOARD
New York State

# 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)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

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

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

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

# Instructions for Completing Form C-3, "Employee Claim"

Please complete this form and send it to the Workers' Compensation Board centralized mailing address listed at the bottom of these instructions. If you need additional help in completing this form, contact the Workers' Compensation Board at **1-877-632-4996. You may also fill this form out online at: http://www.wcb.ny.gov/**

**If you do not have or know your Workers' Compensation Board Case Number, please leave this field blank. It is not required to process your claim. Remember to enter your name and the date of your injury/illness on the top of page two.**

### Section A - Your Information (Employee):

**Item 1:** Enter your full name, including first name, middle initial, and last name.
**Item 2:** Enter your date of birth in month/day/year format. Include the four digit year.
**Item 3:** Enter your mailing address, including P.O. Box, if applicable, city or town, state, and Zip code.
**Item 4:** Enter your Social Security Number. This is very important to help service your claim faster.
**Item 5:** Indicate the primary contact phone number, including area code. This may include a cell phone number.
**Item 6:** Indicate your gender (Male or Female).
**Item 7:** Board hearings are conducted in English. If you will need a translator to understand the proceeding, the Board will provide one. Check Yes and indicate the language needed.

### Section B - Your Employer(s):

**Item 1:** Indicate the employer you were working for at the time you were injured or became ill.
**Item 2:** Enter the phone number for this employer, either a primary contact number or the number for your supervisor.
**Item 3:** Enter the employer's address, including P.O. Box, if applicable, city or town, state, and Zip code.
**Item 4:** Indicate the date you were hired by this employer.
**Item 5:** Enter your direct supervisor's name, whom you report to on a regular basis.
**Item 6:** If you have more than one job, please indicate the names and addresses of all other employers you work for besides the one you were injured at. Please attach a separate sheet if you need more room.
**Item 7:** Check Yes if you lost time from any of your other jobs as a result of your injury or illness; otherwise, check No.

### Section C - Your Job on the Date of the Injury or Illness:

**Item 1:** Indicate your current job title or job description (e.g., warehouse worker).
**Item 2:** Indicate your typical work activities for this job (e.g., keeping inventory, unloading trucks, etc.).
**Item 3:** Check the type of job you had.
**Item 4:** Enter your gross pay (before taxes) per pay period.
**Item 5:** Indicate how often you received a paycheck (weekly, bi-weekly, etc.).
**Item 6:** Indicate if you received any tips or lodging in addition to your regular pay. If you did, describe them.

### Section D - Your Injury or Illness:

**Item 1:** Enter the date when you were injured or the first date you noticed you became ill. Enter the date in month/day/year format. Include the four digit year. If this is an illness or occupational disease, then skip item 2.
**Item 2:** Enter the time when the injury occurred. Check whether it was AM or PM.
**Item 3:** Indicate the location where the injury/illness occurred, including the address of the building and the physical location in the building where the injury/illness happened.
**Item 4:** Check whether this was your normal work location. If it was not, explain why you were at this location.
**Item 5:** Describe in detail what you were doing at the time of the injury/illness (e.g., unloading boxes from a truck by hand). This explains the events leading up to the injury.
**Item 6:** Describe in detail how the injury/illness occurred (e.g., I was lifting a heavy box off a truck). This should include all people and events involved in the injury/illness.
**Item 7:** Indicate fully the nature and extent of your injury/illness, including all body parts injured. Be as specific as possible. (e.g., I strained my back trying to lift a heavy box. It hurts to bend over or hold even lighter objects now.)
**Item 8:** Indicate if some object was involved in the accident OTHER THAN a licensed motor vehicle. Other objects may include a tool (e.g., hammer), a chemical (e.g., acid), machinery (e.g., forklift or drill press), etc.
**Item 9:** Indicate if a licensed motor vehicle was involved in the accident. If so, check if the motor vehicle involved was yours, your employer's, or a third party's. Include the license plate number (if known). If your vehicle was involved, fill out the name and address of your automobile liability insurance carrier.
**Item 10:** Check if you gave your employer or supervisor notice of your injury or illness. If so, indicate who you gave notice to as well as if it was orally or in writing. Include the date you gave notice.
**Item 11:** Check if anyone else saw the injury happen. If anyone did see it, include their name(s).

### Section E - Return to Work:

**Item 1:** If you stopped working as a result of your work-related injury/illness, check Yes and indicate on what date you stopped working. If you have not stopped working, check No and skip to the next section.

### Section E - Return to Work (cont):

**Item 2:** If you have since returned to work, check Yes. Also indicate on what date you started working again, as well as if you have returned to your Normal Duties or if you are on Limited or Restricted Duty. (If you have not returned to your full pre-injury or illness work duties, then you are on Limited Duty.)
**Item 3:** If you have returned to work, indicate who you are working for now.
**Item 4:** Enter your gross pay (before tax pay) per pay period for the job you are working at now. Indicate how often you are receiving a paycheck (weekly, bi-weekly, etc.).

### Section F - Medical Treatment for This Injury or Illness:

**Item 1:** If you did not receive medical treatment for this injury/illness, check None Received and skip to item 5. Otherwise, enter the date you first received treatment for this injury/illness and complete the rest of this section.
**Item 2:** Check if you were first treated on the job for this injury or illness.
**Item 3:** Check the location where you first received off site medical treatment for your injury or illness. Include the name and address of the facility as well as the phone number (including area code).
**Item 4:** If you are still receiving ongoing treatment for the same injury or illness, check Yes and indicate the name and address of the doctor(s) providing treatment as well as the phone number (including area code); otherwise check No.
**Item 5:** If you believe you already had an injury to the same body part or a similar illness, check Yes and indicate if you were treated by a doctor for this injury or illness. If you were treated by a doctor, indicate the name(s) and address(es) of the doctor(s) whom provided care and **complete and file Form C-3.3 together with this form.**
**Item 6:** If you had a previous injury or illness, check if your previous injury or illness was work-related. If Yes, check if the injury or illness happened while working for your current employer.

Sign Form C-3 in the place provided for "Employee's Signature on page 2, print your name, and enter the date you signed the form. If a third-party is signing on behalf of the employee, that person should sign on the second signature line. If you have legal representation, your representative **must** complete and sign the attorney/representative's certification section on the bottom of page 2.

### What Every Worker Should Do in Case of On-The-Job Injury or Occupational Disease:

1. Immediately tell your employer or supervisor when, where and how you were injured.
2. Secure medical care immediately.
3. Tell your doctor to file medical reports with the Board and with your employer or its insurance carrier.
4. Make out this claim for compensation and send it to the Workers' Compensation Board centralized mailing address. Failure to file within two years after the date of injury may result in your claim being denied. If you need help in completing this form, contact the Workers' Compensation Board at 1-877-632-4996.
5. Go to all hearings when notified to appear.
6. Go back to work as soon as you are able; compensation is never as high as your wage.

### Your Rights:

1. Generally, you are entitled to be treated by a doctor of your choice, provided he/she is authorized by the Board. If your employer is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the preferred provider organization which has been designated to provide health care services for workers' compensation injuries.
2. DO NOT pay your doctor or hospital. Their bills will be paid by the insurance carrier if your case is not disputed. If your case is disputed,
the doctor or hospital must wait for payment until the Board decides your case. In the event you fail to prosecute your case or the Board decides against you, you will have to pay the doctor or hospital.
3. You are also entitled to be reimbursed for drugs, crutches, or any apparatus properly prescribed by your doctor and for carfares or other necessary expenses going to and from your doctor's office or the hospital. (Get receipts for such expenses.)
4. You are entitled to compensation if your injury keeps you from work for more than seven days, compels you to work at lower wages, or results in permanent disability to any part of your body.
5. Compensation is payable directly and without waiting for an award, except when the claim is disputed.
6. Injured workers or dependents of deceased workers may represent themselves in matters before the Board or may retain an attorney or licensed representative to represent them. If an attorney or licensed representative is retained, his/her fee for legal services will be reviewed by the Board and if approved will be paid by the employer or insurance company out of any compensation benefits due. Injured workers or dependents of deceased workers should not directly pay anything to the attorney or licensed representative representing them in a compensation case.
7. If you need help returning to work, or with family or financial problems because of your injury, contact the Workers' Compensation Board office nearest you and ask for a rehabilitation counselor or social worker.

**This form should be filed by sending directly to the address listed below:**

**New York State Workers' Compensation Board**
**Centralized Mailing**
**PO Box 5205**
**Binghamton, NY 13902-5205**

**Customer Service Toll-Free Number: 877-632-4996**

Cross Bay Physical Medicine and Rehabilitation, P.C.
Cross Bay Foot Care Center
Cross Bay Physical Therapy
Phone: (718) 835-0100
Fax: (718) 843-2233

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**Workers Compensation Patient Check - List**

Patient Name:___________________________________
Date:_______________________

**All Workers Compensation Patients' need to supply our office with:**

1. Attorney information including name, address, and phone number.
2. All Accident Reports.
3. All information from Insurance Company, including the Claim Number, Claim Representative, their phone number, Date of Accident.
4. All other Insurance information unrelated to your accident.
5. Please inform us when your **work status changes.**
6. Please inform us, when you are scheduled for a Workers Compensation Hearing, or an **independent medical review (IME).**

If you have any questions regarding above policy, please do not hesitate to ask our Workers Compensation Case Specialist.

Thank You.

Patient Signature: ______________________Date:___________________

Copy Given to Patient: __________________Date:___________________

# NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

| WCB CASE NO. (If Known) | CARRIER CASE NO. (If Known) | DATE OF INJURY | NATURE OF INJURY OR ILLNESS | INJURED PERSON'S SOC. SEC. NO. |
|---|---|---|---|---|
| | | | | |

| | | |
|---|---|---|
| CLAIMANT | NAME | ADDRESS APT. NO. |
| EMPLOYER | | |
| INSURANCE CARRIER | | |

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature__________________________________________ Date ____________________

Provider's Name and Address ____________________________________________________________

________________________________________________________________________________________

**TO THE CLAIMANT**

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

**Workers' Compensation Law Section 32**

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

**TO THE HEALTH CARE PROVIDER**

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.

# ADVIERTA QUE USTED PUEDE LLEGAR A SER RESPONSABLE POR LOS COSTOS MÉDICOS EN CASO DE ABANDONO DEL PROCESO, O SI SE RECHAZA LA SOLICITUD DE INDEMNIZACIÓN, O SI SE APRUEBA UN ACUERDO EN VIRTUD DE LA LEY DE INDEMNIZACIÓN LABORAL WCL §32

| Nº DE CASO WCB (si se conoce) | Nº. DE CASO DE LA ASEGURADORA (si se conoce) | FECHA DE LA LESIÓN | NATURALEZA DE LA LESIÓN O ENFERMEDAD | Nº SEG. SOC. DE PERSONAS LESIONADAS |
|---|---|---|---|---|
| | | | | |
| RECLAMANTE | NOMBRE | | DIRECCIÓN | APT. NO. |
| EMPLEADOR | | | | |
| COMPAÑÍA DE SEGUROS | | | | |

Usted puede llegar a ser responsable por hacer el pago de los costos médicos del tratamiento de su enfermedad o condición al proveedor que se indica a continuación si (1) abandona el proceso de compensación laboral (2) si la institución Workers' Compensation Board (Junta de Compensación Laboral) determina que la enfermedad o condición que requería tratamiento no ocurrió por un accidente de trabajo indemnizable o enfermedad ocupacional o (3) si el acuerdo fue tramitado por usted y aprobado conforme a la Ley de Indemnización de Trabajadores WCL §32 ; en virtud de esta ley, usted renuncia a sus derechos de obtener los beneficios médicos de la compañía aseguradora de indemnizaciones laborales o del empleador auto asegurado para cubrir los tratamientos y servicios realizados después de la fecha en que se aprobó el acuerdo. Si ocurriera cualquiera de los hechos mencionados con anterioridad, el proveedor podrá cobrarle directamente el costo por los servicios recibidos en lugar de hacerlo al empleador o a la compañía aseguradora, y usted será responsable por hacer los pagos correspondientes.

Por medio de la presente reconozco que he leído el párrafo anterior y que entiendo las circunstancias bajo las cuales me hago responsable del pago.

Firma del reclamante ______________________________ Fecha__________________

Nombre y dirección del proveedor________________________________________

**AL RECLAMANTE**

La Regulación 325-1.23 de la institución Workers' Compensation Board (Junta de Compensación Laboral) permite que su doctor o terapeuta le solicite que firme esta notificación A-9. Al firmar esta notificación, usted reconoce la obligación de pagar los honorarios al proveedor por los servicios que recibe en el supuesto caso que la ley no requiera que su empleador o aseguradora de indemnización laboral pague tales honorarios y si tales honorarios no están cubiertos por otro seguro. Es posible que el empleador o aseguradora no deba pagar los honorarios médicos si, por ejemplo, usted no presenta una solicitud de indemnización laboral, o si no notifica su lesión o enfermedad a su empleador, o si no asiste a la audiencia de la institución Workers' Compensation Board si su empleador desafía sus derechos a los beneficios. Aun cuando hubiese realizado todos los trámites necesarios para procesar su solicitud, la institución Workers' Compensation Board puede decidir que usted no tiene derecho a los beneficios. En tal caso, esta notificación le aconseja a su proveedor de servicios de salud que usted reconozca su responsabilidad personal por el pago de sus cuentas.

**Artículo 32 de la Ley de Indemnización Laboral (WCL 32)**

La notificación A-9 también cubre las instancias en las que un reclamante por un caso de compensación laboral válido existente llega a un acuerdo con su empleador/a o su compañía aseguradora tras resolver su caso según el artículo 32 de la ley WCL. Un acuerdo según el Artículo 32 puede incluir una cláusula que libere al empleador/a o aseguradora de la responsabilidad de pagar en el futuro cuentas médicas asociadas con el caso. Su proveedor de servicios médicos puede solicitar que usted firme esta notificación A-9 para garantizar que reconoce su responsabilidad personal por el pago de sus cuentas si renunció al derecho de recibir beneficios médicos futuros mediante un acuerdo conforme al artículo 32.

Si tiene alguna pregunta, comuníquese con su abogado o representante autorizado para la audiencia, de tener uno. También puede comunicarse con la institución Workers' Compensation Board (Junta de Compensación Laboral) en la oficina de su distrito.

**AL PROVEEDOR DE SERVICIOS DE SALUD**

Esta notificación tiene el fin de avisar al reclamante de indemnización laboral que puede ser responsable del pago. Si el reclamante no firma este formulario, no libera con este acto al proveedor de su obligación de tratar al reclamante, ni tampoco anula la responsabilidad de pago por parte del reclamante.

Mantenga el original de este formulario en sus propios registros y entregue una copia al reclamante. **No lo presente en la institución Workers Compensation Board** (Junta de Compensación Laboral)**.** Usted recibirá notificaciones de las decisiones en las que se incluirá si la solicitud es indemnizable, la autorización del tratamiento o el pago de cuentas médicas. También se le notificará si el reclamante presenta un acuerdo conforme al Artículo 32 para que lo apruebe la institución Workers' Compensation Board. No cobre al reclamante a menos que y hasta que usted reciba una decisión de la institución Workers Compensation Board que indique: 1) que el reclamante no procesará la solicitud, o 2) que la solicitud fue rechazada, o 3) que el tratamiento no tiene relación causal con las lesiones laborales, o 4) que se aprobó un acuerdo conforme al Artículo 32 liberando a la aseguradora de la responsabilidad por el tratamiento médico.



Establecido por la presidencia de Workers' Compensation Board, Estado de Nueva York (www.wcb.ny.gov)

**THIS NOTICE IS WRITTEN IN ENGLISH ON THE REVERSE SIDE.**

**DOWNSTATE CENTRALIZED MAILING**
**(for New York City, Hempstead, Hauppauge & Peekskill Districts)**
**PO Box 5205 Binghamton, NY 13902-5205**
NYC (800)877-1373 / Hemp. (866)805-3630 / Haup. (866)681-5354 / Peek. (866)746-0552

100 Broadway
Menands
ALBANY 12241
(866) 750-5157

State Office Building
44 Hawley Street
BINGHAMTON 13901
(866) 802-3604

Statler Towers
107 Delaware Ave.
BUFFALO 14202
(866) 211-0645

130 Main Street W.
ROCHESTER 14614
(866) 211-0644

935 James St.
SYRACUSE 13203
(866) 802-3730

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 |
|---|---|---|
| | | |

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, ______________________________,
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

______________________________________________________________, at
Name of a Specific Person, Corporation, Association or Public or Private Entity

______________________________________________________________.
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.

______________________________ ____________________
Claimant's Signature (ink only) 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.