OMB No. 0920-0891
Exp. Date 05/31/2028

9.11 World Trade Center Health Program

HIPAA Authorization for Designated Representatives

INSTRUCTIONS: This form is for use when a World Trade Center (WTC) Health Program applicant or member wants to appoint a Designated Representative to represent their interests under the Program. If you choose to appoint a Designated Representative (such as with the WTC Health Program Designated Representative Appointment Form), you must also submit this form regarding the individual you are appointing as your Designated Representative. This form must be filled out in its entirety by the WTC Health Program applicant or member.[1]

Please return all documents to the WTC Health Program via mail ATTN: WTC Health Program Privacy Officer at P.O. Box 7000 Rensselaer, NY 12144 or via fax at 404-448-4485.

I,_____, give permission to the U.S.
(Name of Applicant or Member)
Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Institute for Occupational Safety and Health (NIOSH), World Trade Center (WTC) Health Program, including federally-funded contractors acting on behalf of and funded by the WTC Health Program, to use and/or disclose my protected health information, as described below, to _____ for the purposes of him/her
(Name of Designated Representative)
acting on my behalf and representing my interests in the WTC Health Program, as permitted in 42 C.F.R. pt. 88. Information to be disclosed to my Designated Representative may include any and all information relevant to the Designated Representative representing my interests in the WTC Health Program, including protected health information contained in medical, treatment, and diagnostic records as necessary.

I wish to exclude the following information from such authorized disclosures to my Designated Representative (describe):

This authorization expires

- ☐ on the following date or event:_____
- ☐ at the expiration of the WTC Health Program[2][1]

or at such time as I exercise my right to revoke this authorization in writing, whichever happens earlier. I may revoke this authorization in writing at any time by sending written notification to the address listed above. Use or disclosure of my protected health information by the WTC Health Program made prior to the Program's receipt of my written request to revoke this authorization will be governed by this authorization to the extent that the Program has taken any action in reliance on this authorization already.

Signing this authorization is voluntary. The WTC Health Program may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. The information governed by this authorization may be subject to further disclosure by the authorized recipient(s); such additional disclosures by third parties are not subject to, nor protected by, this authorization. The WTC Health Program will give me a copy of this signed authorization, upon request. (Requests may be made in writing to the above address.)

1 If the signatory is not the applicant or member, please include documentation demonstrating the signatory's legal authority to act on behalf of the applicant/member for HIPAA-authorized purposes.

2 The expiration of the WTC Health Program is defined as when the Program is no longer funded and is unable to provide services under Title XXXIII of the Public Health Service Act, currently 2090.

Printed Name of Applicant/Member	**Date of Birth**
Address	**WTC Health Program ID (911#), if known**
Address Line 2	**Phone**
Applicant/Member Signature	**Date**