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

9.11 World Trade Center Health Program

HIPAA Authorization for Disclosures Regarding Deceased Individuals

INSTRUCTIONS: If you choose to submit this form, it must be filled out in its entirety on behalf of a deceased applicant/member of the World Trade Center Health Program. In addition to the form itself, please include:

- Documentation demonstrating your **legal authority to act on behalf of the decedent or their estate.** This is typically obtained through your local probate or surrogate's court.
- Documentation verifying **your identity** as the personal representative, such as a copy of your driver's license or other government identification.
- Documentation verifying the **identity of the recipient** if you are requesting records to be sent to a third party.

Please return all documents to the WTC Health Program via mail ATTN: WTC Health Program Privacy Officer at 400 7th Street SW, Suite 5W, Washington D.C., 20024 or via fax at 404-448-4485.

I,_____ , give permission to the U.S. 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[1] to disclose the following protected health information related to:

_____

(NAME OF DECEASED INDIVIDUAL AND WTC HEALTH PROGRAM ID (911#), IF KNOWN)

_____

(DATE OF BIRTH OF INDIVIDUAL)

_____

(DATE OF DEATH OF INDIVIDUAL)

To the following individual or entity:

_____

(NAME OF RECIPIENT)

_____

(ADDRESS OF RECIPIENT)

_____

(TELEPHONE NUMBER OF RECIPIENT)

_____

(EMAIL ADDRESS OF RECIPIENT, IF KNOWN)

1 For purposes of this document, all references to the WTC Health Program include NIOSH to the extent that it administers the WTC Health Program, as well as all contractors who are business associates of the WTC Health Program and conduct activities on behalf of the WTC Health Program, including but not limited to the Clinical Centers of Excellence and Nationwide Provider Network.

For the following purpose:

The information to be disclosed will be the minimum necessary for the third party to carry out its purpose and may include (please check all that apply and describe if there are any exclusions within each checked category):

- ☐ WTC Health Program certification decision letters, including certification denial decisions/letters (This letter lists conditions for which the WTC Health Program has determined are related to or medically associated with the member's 9/11 exposures)

  Please list any exclusions to the WTC Health Program's disclosure of its certification decisions/letters:

  _____

- ☐ WTC Health Program enrollment decision letters (This letter confirms a member's successful enrollment in the WTC Health Program) and application materials (documents that the WTC Health Program used to determine the individual's eligibility for enrollment)

  Please list any exclusions to the WTC Health Program's disclosure of its enrollment application materials:

  _____

And, if requested:

- ☐ Medical Records, including treatment and diagnostic records. Please note that medical records requests will be forwarded to the member's clinic for fulfillment.

  Please list any exclusions to the WTC Health Program's disclosure of its Medical Records:

  _____

- ☐ Other Records: _____

  Please list any exclusions to the WTC Health Program's disclosure of its Other Records:

  _____

- ☐ Other Exclusions: _____

This authorization expires when the information requested is provided to the above-named recipient, 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 Program: **ATTN: HIPAA Privacy Officer: 400 7th Street SW, Suite 5W, Washington D.C., 20024.** 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 the signing of this authorization, as applicable. The information disclosed under 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.)

Please fill in the appropriate state/territory below and attach the appropriate documentation with this release.

By signing this authorization, I certify that I possess legal authority to act on behalf of the decedent or the decedent's estate based on the laws of _____(State).

I am attaching documentation of such legal authority and understand that the WTC Health Program may require additional information.

By my signature I attest that I have provided truthful and accurate information and that I understand the following: Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to the United State Government is subject to civil and/or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both pursuant to 18 U.S.C. § 1001.

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