WELCOME

PATIENT INFORMATION

DATE: _____
SS/ID# _____
PATIENT NAME _____
LAST NAME
FIRST NAME _____ MIDDLE INITIAL _____
ADDRESS _____
CITY _____
STATE _____ ZIP _____
EMAIL _____@_____
SEX ☐M ☐F AGE _____
BIRTHDAY _____

☐MARRIED ☐WIDOWED ☐SINGLE ☐MINOR
☐SEPARATED ☐DIVORCED ☐PARTNERED FOR ___ YEARS

OCCUPATION _____
PATIENT EMPLOYER/SCHOOL _____
EMPLOYER/SCHOOL ADDRESS _____
_____
EMPLOYER/SCHOOL PHONE (___)_____-_____
SPOUSE'S NAME _____
BIRTHDAY _____
SS# _____
SPOUSE EMPLOYER _____
WHOM MAY WE THANK REFERRING YOU? _____

INSURANCE

WHO IS RESPONSIBLE FOR THIS ACCOUNT?
_____
RELATIONSHIP TO PATIENT _____
INSURANCE CO. _____
GROUP # _____

IS PATIENT COVERED BY ADDITIONAL INSURANCE? ☐Y☐N
SUBSCRIBER'S NAME _____
BIRTHDATE _____ SS# _____
RELATIONSHIP TO PATIENT _____
INSURANCE CO. _____
GROUP # _____

ASSIGNMENT AND RELEASE

I CERTIFY THAT I, AND/ OR MY DEPENDANT(S) HAVE INSURANCE COVERAGE WITH _____
NAME OF INSURANCE COMPANY

AND ASSIGN DIRECTLY TO DR. ERIC GOLDBERG 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 FOR ALL INSURANCE SUBMISSIONS. THE ABOVE-NAMED DOCTOR MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE- NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENTS FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

DATE _____ _____ RELATIONSHIP TO PATIENT

PHONE NUMBERS

HOME PHONE (___)_____
CELL PHONE (___)_____
BEST TIME AND PLACE TO REACH YOU
_____
IN CASE OF EMERGENCY, CONTACT

NAME _____
RELATIONSHIP _____
HOME # (___)_____
WORK # (___)_____

ACCIDENT INFORMATION

IS CONDITION DUE TO AN ACCIDENT? ☐YES ☐NO
DATE _____
TYPE OF ACCIDENT ☐AUTO ☐WORK ☐HOME ☐ OTHER

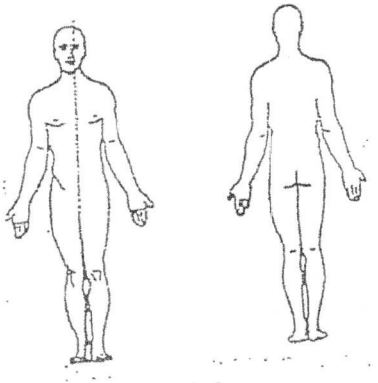
TO WHOM HAVE YOU MADE A REPORT OF YOUR ACCIDENT?
☐AUTO INSURANCE ☐EMPLOYER ☐WORKERS COMPENSATION
☐ OTHER
ATTORNEY NAME (IF APPLICABLE)
_____

PATIENT CONDITION

REASON FOR VISIT _____ HEIGHT _____ WEIGHT _____

WHEN DID YOUR SYMPTOMS APPEAR? _____
IS CONDITION GETTING PROGRESSIVELY WORSE? ☐YES ☐NO ☐ UNKNOWN

MARK AN X ON THE PICTURE WHERE YOU CONTINUE TO HAVE PAIN, NUMBNESS, OR TINGLING.



RATE THE SEVERITY OF YOUR PAIN ON A SCALE FROM 1(LEAST PAIN) TO 10 (SEVERE PAIN). ____
TYPE OF PAIN: ☐ SHARP ☐DULL ☐ THROBBING ☐ NUMBNESS ☐ACHING ☐ SHOOTING
☐BURNING ☐ TINGLING ☐ CRAMPS ☐STIFFNESS ☐ SWELLING ☐ OTHER

HOW OFTEN DO YOU HAVE THIS PAIN? _____
IS IT CONSTANT OR DOES IT COME AND GO? _____

DOES IT INTERFERE WITH YOUR ☐ WORK ☐SLEEP ☐ DAILY ROUTINE ☐RECREATION
ACTIVITIES OR MOVEMENTS THAT ARE PAINFUL TO PERFORM ☐SITTING ☐STANDING ☐ WALKING ☐ BENDING ☐LYING DOWN

HEALTH HISTORY

WHAT TREATMENT HAVE YOU ALREADY RECEIVED FOR YOU CONDITION?

MEDICATIONS SURGERY PHYSICAL THERAPY CHIROPRACTIC SERVICES NONE
OTHER _____

NAME AND ADDRESS OF OTHER DOCTORS WHO HAVE TREATED YOUR CONDITION _____

DATE OF LAST: PHYSICAL EXAM _____ SPINAL X-RAY _____ BLOOD TEST _____
SPINAL EXAM _____ CHEST X-RAY _____ URINE TEST _____
DENTAL X-RAY _____ MRI, CT-SCAN, BONE SCAN _____

PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU HAVE ONE OF THE FOLLOWING:

AIDS/HIV ☐YES ☐ NO	DIABETES ☐YES ☐ NO	MIGRAINE-HEADACHES ☐YES ☐ NO	STROKE ☐YES ☐ NO
ALCOHOLISM ☐YES ☐ NO	EMPHYSEMA ☐YES ☐ NO	MISCARRIAGE ☐YES ☐ NO	SUICIDE ATTEMPT ☐YES ☐ NO
ALLERGIES SHOT ☐YES ☐ NO	EPILEPSY ☐YES ☐ NO	MONONUCLEOSIS ☐YES ☐ NO	THYROID PROBLEMS☐YES☐ NO
ANEMIA ☐YES ☐ NO	FRACTURES ☐YES ☐ NO	MULTIPLE SCLEROSIS ☐YES☐ NO	TONSILLITIS ☐YES☐ NO
ANOREXIA ☐YES ☐ NO	GLAUCOMA ☐YES ☐ NO	MUMPS ☐YES ☐ NO	TUBERCULOSIS ☐YES ☐ NO
APPENDICITIS ☐YES ☐ NO	GOITER ☐YES ☐ NO	OSTEOPOROSIS ☐YES ☐ NO	TUMORS GROWTH ☐YES ☐ NO
ARTHRITIS ☐YES ☐ NO	GONORRHEA ☐YES ☐ NO	PACEMAKER ☐YES ☐ NO	THYROID FEVER ☐YES ☐ NO
ASTHMA ☐YES ☐ NO	GOUT ☐YES ☐ NO	PARKINSON'S DISEASE ☐YES ☐ NO	ULCERS ☐YES ☐ NO
BLEEDING DISORDERS ☐YES ☐ NO	HEART DISEASE ☐YES ☐ NO	PINCHED NERVE ☐YES ☐ NO	VAGINAL INFECTIONS ☐YES ☐NO
BREAST LUMP ☐YES ☐ NO	HEPATITIS ☐YES ☐ NO	PNEUMONIA ☐YES ☐ NO	VENEREAL DISEASE ☐YES ☐NO
BRONCHITIS ☐YES ☐ NO	HERNIA ☐YES ☐ NO	POLIO ☐YES ☐ NO	WHOOPING COUGH ☐YES☐ NO
BULIMIA ☐YES ☐ NO	HERNIATED DISK ☐YES ☐ NO	PROSTATE PROBLEM ☐YES ☐ NO	OTHER
CANCER ☐YES ☐ NO	HERPES ☐YES ☐ NO	PROSTHESIS ☐YES ☐ NO	
CATARACTS ☐YES ☐ NO	HIGH CHOLESTEROL ☐YES ☐ NO	PSYCHIATRIC CARE ☐YES ☐ NO	
CHEMICAL ☐YES ☐ NO	KIDNEY DISEASE ☐YES ☐ NO	RHEUMATOID ARTHRITIS ☐YES ☐ NO	
DEPENDENCY ☐YES ☐ NO	LIVER DISEASE ☐YES ☐ NO	RHEUMATIC FEVER ☐YES ☐ NO	
CHICKEN POX ☐YES ☐ NO	MEASLES ☐YES ☐ NO	SCARLET FEVER ☐YES☐ NO	

EXERCISE	WORK ACTIVITY	HABITS	
☐ NONE	☐ SITTING	☐ SMOKING	PACKS A DAY _____
☐MODERATE	☐ STANDING	☐ALCOHOL	DRINKS/WEEK _____
☐DAILY	☐ LIGHT LABOR	☐COFFEE/CAFFEINE DRINKS	CUPS/DAY _____
☐HEAVY	☐ HEAVY LABOR	☐HIGH STRESS LEVEL	REASON _____

ARE YOU PREGNANT? ☐YES ☐ NO DUE DATE _____

INJURIES/SURGERIES YOU HAVE HAD

	DESCRIPTION	DATE
FALLS		
HEAD INJURIES		
BROKEN BONES		
DISLOCATIONS		
SURGERIES		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
PHARMACY NAME _____		
PHARMACY TEL# _____		

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

NAME _____ BIRTHDAY _____

SIGNATURE _____

DATE _____

TOTAL MEDICAL N.Y. PC
93-24 QUEENS BLVD. SUITE 1G
REGO PARK, NY, 11374
(T) 718-730-9040 (F) 718-730-9043

ASSIGNMENT AND RELEASE

I CERTIFY THAT I, AND/ OR MY DEPENDANT(S) HAVE INSURANCE COVERAGE WITH

_____
NAME OF INSURANCE COMPANY

AND ASSIGN DIRECTLY TO **DR. ERIC GOLDBERG** 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 FOR ALL INSURANCE SUBMISSIONS. THE ABOVE-NAMED DOCTOR MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE- NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENTS FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

_____
SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

_____
PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

_____ _____
DATE RELATIONSHIP TO PATIENT

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective: February 12, 2014

LAYERED SUMMARY TEXT –

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Signature of Patient_____Print Name of Patient: _____Date: _____

Patient Summary Form

PSF-760 (Rev.2/18/2009)

Instructions
Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.
*Fax number may vary by plan.

Patient Information

Patient name: Last | First | MI

○ Female ○ Male

Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)

2. Federal tax ID(TIN) of entity in box #1

1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other _____

3. Name and credentials of the individual performing the service(s)

4. Alternate name (if any) of entity in box #1 | 5. NPI of entity in box #1 | 6. Phone number

7. Address of the billing provider or facility indicated in box #1 | 8. City | 9. State | 10. Zip code

Provider Completes This Section*

Date you want *THIS* submission to begin:

Cause of Current Episode
1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery

Type of Surgery
1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other _____

Diagnosis (ICD code)
Please ensure all digits are entered accurately
1° 2° 3° 4°

Patient Type
1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Nature of Condition
1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level
○ 98940 ○ 98942 ○ 98941 ○ 98943

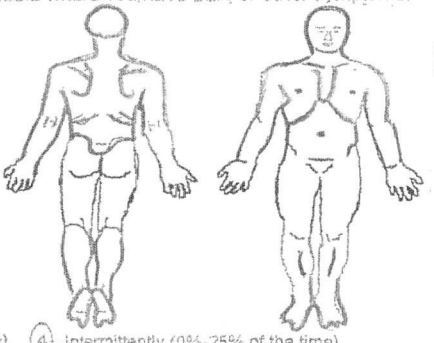
Current Functional Measure Score
Neck Index | DASH | (other)
Back Index | LEFS

Patient Completes This Section*

(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:



1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

4. How often do you experience your symptoms?
(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)
(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. How is your condition changing, since care began at *this* facility?
(0) N/A — This is the initial visit (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

7. In general, would you say your overall health right now is...
(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

Patient Signature: X _____ Date: _____

WORKER COMPENSATION INFORMATION

Date_____

PATIENT INFORMATION

Name_____ Birthdate_____ Soc. Sec. #_____

Address_____

_____

Telephone_____ Occupation_____

EMPLOYER

Employer Name_____

Employer Address_____

_____

Employer Telephone_____ Injury Verified By (For Office Use)_____

Contact Person_____

WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Worker Compensation Carrier_____

Carrier Address_____

_____

Carrier Phone Number_____ Coverage Verified by_____

Adjuster's Name_____ Claim Number_____

INJURY INFORMATION

Date of Injury_____ Time_____ ☐ AM ☐ PM

Place of Injury_____

Accident reported to employer? ☐ Yes ☐ No Name of person you reported accident to_____

Give full description of how accident happened_____

_____

_____

_____

_____

Have you lost time from work? ☐ Yes ☐ No How much?_____

Other doctors seen for this condition:

Doctor's Name_____ Diagnosis_____

Were X-Rays taken? ☐ Yes ☐ No Other Tests? ☐ Yes ☐ No

If yes, by whom? Please list test(s) and result(s)_____

_____

_____

_____

Any previous Worker Compensation injuries? ☐ Yes ☐ No Date(s) of previous injuries_____

Describe previous Worker Compensation injuries_____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Workers Compensation benefits is denied.

Patient's Signature_____ Date_____

WC

PATIENTS NAME:_____ DATE:_____

IS PATIENT DISABLED? YES___ NO___ TOTAL___ PARTIAL___

FIRST DATE OF DISABILITY? ___/___/___

IS PATIENT WORKING? YES___ NO___

DATE RESUMED? ___/___/___ LIMITED___ REGULAR___

NEW YORK STATE | Workers' Compensation Board

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

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

PO Box 5205, Binghamton, NY 13902-5205 • www.wcb.ny.gov

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

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

Claimant's Name	Claimant's Social Security or Tax Identification Number	Case Number ☐ WCB ☐ DB ☐ Discrimination ☐ PFL and/or Date of Accident

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

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 cases(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.

_____ _____

Claimant's Signature (ink only - use blue ink 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.

OC-110A 12-17