Lerman Diagnostic Imaging
6511 Fort Hamilton Parkway • Brooklyn, NY 11219
Tel: 718 491-4545 • Fax: 718 491-4123

Authorization for Use and Disclosure of Private Health Information
Worker's Compensation Information Form

Name: _____

Date of Birth: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Employer's Name: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Attorney's Name: _____

Attorney's Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Compensation Carrier Name: _____

Carrier's Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Compensation Carrier Case #/Claim #: _____ Date of Injury: _____

Worker's Compensation Board (WCB) Case # (if known): _____

The responsible party in a Worker's Compensation case is the insurance carrier for the employer. However, the patient is ultimately the responsible party in the event that the employer's carrier does not accept the claim as a Worker's Compensation related injury. I hereby irrevocably assign payment to Lerman Diagnostic Imaging for medical services rendered to me.

I hereby authorize Lerman Diagnostic Imaging to disclose all information concerning this illness and/or injury to my compensation carrier and any legal entities involved in the litigation resulting from my illness and/or injury. This authorization will be in force and effect from this day forward, however, I do understand that I have the right to revoke this authorization at any time, in writing, by mailing such written notification to the Office Manager at the above address

I understand that a revocation is not effective to the extent that Lerman Diagnostic Imaging has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or to contest the policy itself.

I understand that Lerman Diagnostic Imaging will not condition my treatment on whether I provide authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment on obtaining this authorization, I have been advised of that fact and of the consequences to me of refusing to sign this authorization

I understand that there is a potential for information used or disclosed pursuant to this authorization to be subject to redisclosure by the recipient if the recipient is not required by law to protect the privacy of the information.

I understand that I will receive a copy of this authorization, if requested.

Signature: _____ Date: _____
(if minor, parent/legal guardian)

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.