



World Trade Center Health Program
Designated Representative

Form Approved
OMB No. 0920-0891
Exp. Date 12/31/2021

Health Insurance Portability and Accountability Act (HIPAA) Authorization

I, [Name], 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, including a federally funded contractor acting on behalf of and funded by the WTC Health Program, to use and/or disclose the protected health information described below to [INSERT NAME OF DESIGNATED REPRESENTATIVE] for the purposes of him/her 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.

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

This authorization expires at the expiration of the WTC Health Program (when the Program is no longer funded and is unable to provide services under Title XXXIII of the Public Health Service Act) or at such time as I exercise my right to revoke this authorization in writing. I may revoke this authorization in writing at any time, prior to the expiration of the WTC Health Program, by sending written notification to HIPAA Privacy Officer at CDC/NIOSH, 395 E Street SW, Suite 9200, Washington DC 20201. Any use or disclosure of 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.

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; 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.

Printed Name, WTC Health Program ID# (begins with 911), Address, City/State/Zip, Phone, Signature, Date

If the signatory is not the individual whose protected health information is the subject of this authorization, state the authority of the signatory to act as the individual's HIPAA personal representative: