



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA
[This form has been approved by the New York State Department of Health]

Patient Name [REDACTED]	Date of Birth [REDACTED]	Social Security Number [REDACTED]
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I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
NYS OFFICE OF VICTIM SERVICES – AE SMITH BLDG., 80 S. SWAN ST., ALBANY, NY 12210-8002

9(a). Specific information to be released:

Medical Record from (insert date) _____ to (insert date) _____

Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

Other: _____ Include: (Indicate by Initialing)

_____ Alcohol/Drug Treatment

_____ Mental Health Information

_____ HIV-Related Information

Authorization to Discuss Health Information

(b) By initialing here _____ I authorize _____ Name of individual health care provider

Initials _____

to discuss my health information with my attorney, or a governmental agency, listed here:

NEW YORK STATE OFFICE OF VICTIM SERVICES

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:
At request of the individual for purposes of establishing eligibility for New York State Office of Victim Services benefits.

11. Date or event on which this authorization will expire:
This authorization will expire upon the termination of the individual's eligibility for Office of Victim Services benefits.

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

[REDACTED] questions about this form have been answered. In addition, I have been provided a copy of this form.

Date: [REDACTED]

The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

Read
How to Apply for
Compensation before
filling out this form.

Application for Compensation

New York State Office of Victim Services



Please print. Answer all questions. It is a crime to file a false claim!

Victim Assistance Program Use Only

OVS VAP ID#	Program Name/Phone	Advocate Name/Email
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1 Tell us about the victim.

Last Name	First Name	MI	Social Security #	Date of Birth

Race/Ethnicity: White Black Asian Hispanic American Indian/Alaskan Native Pacific Islander/Native Hawaiian Other Multi-Race

Marital Status: Single Married Divorced Separated Widowed Lives with partner

Gender: Male Female Was the victim disabled at the time of the crime? Yes No Unknown

How did you first hear about the Office of Victim Services?

Police Hospital District Attorney Victim Assistance Program Radio/TV Brochure/Poster Internet Other

2 If you are not the victim, and you are signing this claim, you are the claimant. Tell us about you. (See "Who can sign the claim?" on the instructions page.)

Last Name	First Name	MI	Social Security # <input type="checkbox"/> Check here if you do not have one.	Date of Birth
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Mailing Address:

Street Apt. # (or P.O. Box) City County State (or Foreign Country) Zip Code

What is your relationship to the victim? (Check only one.)

Parent Spouse Child Legal Guardian Attorney Other (Explain): _____

3 Tell us about the crime. (Check only one.)

The victim died because of:

- Motor Vehicle (DUI/DWI)
- Motor Vehicle (Other)
- Terrorism
- Arson
- Human Trafficking
- Other / homicide: _____

The victim was injured because of:

- Assault Stalking
- Sexual Assault Kidnapping
- Child Physical Abuse/Neglect Terrorism
- Child Sexual Abuse Arson
- Motor Vehicle (DUI/DWI) Robbery
- Motor Vehicle (not DUI/DWI) Human Trafficking
- Child Pornography
- Other (Explain): _____

The victim lost essential personal property because of:

- Burglary Arson
- Motor Vehicle (DUI/DWI) Criminal
- Motor Vehicle (not DUI/DWI) Mischief
- Human Trafficking Fraud/Financial Crime
- Robbery (No injury)
- Other (Explain): _____

Where did the crime happen? (Check only one.) Work Owned residence Apt. Bldg. Public Street

Subway/Bus Parking Lot Restaurant/Bar School/School grounds Shopping Mall Other (Explain): _____

Was this a crime related to domestic violence? Yes No Unknown

Was this a crime related to bullying? Yes No Unknown

Was this a crime related to elder abuse/neglect? Yes No Unknown

Was this a hate crime? Yes No Unknown

Was the victim driving a livery cab when the crime happened? Yes No Unknown

Was the victim's property lost or damaged while trying to prevent or stop a crime against someone else or while helping the authorities stop the crime? Yes No

Crime Report #: _____ Police or criminal justice agency reported to: _____

County where crime happened: _____ Date of crime: _____ Date crime was reported: _____

If more than 7 days between the date of crime and date the crime was reported, explain why: _____

If more than 1 year between the date of crime and the date you are filing this claim, explain why: _____

Describe the crime in your own words: _____

4 Tell us about the suspect. Suspect's name (if you know): I am a victim of Jeffery Epstein

Has the suspect been arrested for this crime? Yes No

Has the suspect been prosecuted for this crime? Yes No Not Yet

Does the suspect live in the same house as the victim OR is the suspect a member of the victim's family? Yes No

Has the court issued an order of protection in this case? Yes No (If Yes, attach a copy.)

Has the DA asked the court to order restitution? Yes No Not Yet

Did the court order the suspect to pay restitution? Yes (Amount \$ _____) No Not Yet

NOTE - If you are eligible for compensation, the OVS may be able to reimburse for the expenses listed below. These items should also be requested as part of court ordered restitution. Applicants are encouraged to share this information with prosecutors if there is a criminal case. See the Court Ordered Restitution Information page for important information about restitution.

5 Tell us about your expenses related to this crime. (Check all that apply.)

Medical/Ambulance Loss of Support Lost Wages Personal Transportation

Crime Scene Cleanup (Death Claim Only) DV Shelter Medical/Counseling

Security Device/System Vocational/Rehabilitation Moving/Storage Court

Counseling Funeral/Burial Essential Personal Property

Other (Explain): _____

6 List any essential personal property, like cash, eyeglasses, or clothing that needs to be replaced because of this crime. (If none, skip to 7.)

Describe what was lost/damaged:	Cost	Describe what was lost/damaged:	Cost
1. _____	\$ _____	3. _____	\$ _____
2. _____	\$ _____	4. _____	\$ _____
3. _____	\$ _____	6. _____	\$ _____

Homeowner/Renter Insurance Company	Policy or ID #	Deductible \$
Auto/Other Insurance Company	Policy or ID #	Deductible \$

— If there were no injuries and you are only asking for essential personal property benefits, skip to 15. —

7 Tell us about the victim's or the parent's employment and insurance for Lost Wages. If you do not want us to contact your employer, you cannot ask to be reimbursed for Lost Wages. (Skip to 8.)

Was the victim/parent of hospitalized minor victim employed when the crime happened? Yes No (If No, skip to 8.)

Did the victim/parent of hospitalized minor victim miss work because of the crime? Yes No

Was the victim/parent self-employed? Yes No (If Yes, attach copies of last year's federal tax return and all schedules.)

Employer's Name, Address, and Phone #:

Employer _____ Street _____ City _____ State _____ Zip Code _____ Phone # _____

Other Employer's Name, Address, and Phone #:

Employer _____ Street _____ City _____ State _____ Zip Code _____ Phone # _____

Name, Address, and Phone # of doctor who certified victim could not go to work:

Doctor _____ Street _____ City _____ State _____ Zip Code _____ Phone # _____

Tell us about any insurance company that will cover the victim's lost time at work. (If none, write "None" below and skip to 8.)

Policy or ID # or "None"		Policy or ID # or "None"	
1. Unemployment Insurance		5. Workers' Compensation	
2. Disability Insurance		6. Other insurance	
3. Pension Plan		7. Social Security Benefits (ssn required)	SSN _____
4. Other insurance		8. SSI Benefits (ssn required)	SSN _____

8 If the victim died, fill out below if you have any burial expenses. (If not, skip to 9.)

Also, attach a copy of the funeral home contract, other bills for burial expenses, and a photocopy of the Death Certificate, if you have them.

Name of Funeral Home: _____ Phone #: _____

Address: _____ Street _____ City _____ State _____ Zip Code _____

9 If the victim was injured or died because of this crime, fill out below.

Describe the victim's injuries, briefly: _____

Did the victim receive any medical treatment? Yes No (If No, skip to section 10.)

Tell us about the health professionals who treated the victim for injuries related to this crime:

	Full Name	Complete Address	Phone #
First Hospital	_____	_____	(____) _____
Other Hospital	_____	_____	(____) _____
First Doctor (not in hospital)	_____	_____	(____) _____
Other Doctor	_____	_____	(____) _____
First Dentist	_____	_____	(____) _____
Victim's Counselor	_____	_____	(____) _____

10 Tell us about the victim's dependents or others who depended on the victim for support. (If none, skip to 11.)

Dependent	Name	Social Security #	Date of Birth	Relationship to Victim
	Address			Are you the legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Dependent	Name	Social Security #	Date of Birth	Relationship to Victim
	Address			Are you the legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Dependent	Name	Social Security #	Date of Birth	Relationship to Victim
	Address			Are you the legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No

If more than 3 dependents, attach a separate sheet and check here:

11 Did anyone besides the victim receive counseling because of this crime? (If no, skip to 12.)

Who received counseling?	Relationship to Victim	Insurance company billed for counseling	Policy or ID #
Counselor's name, address and phone #:			
Who else received counseling?	Relationship to Victim	Insurance company billed for counseling	Policy or ID #
Counselor's name, address and phone #:			

If more than 2 people received counseling because of this crime, check here and attach a separate sheet to describe.

12 List any insurance covering the victim or the victim's dependents. If no insurance, write "None" below. If you have applied but are not covered yet, write "Pending" under Policy or ID #.

	Policy or ID #	Name of person(s) covered by this insurance:
Primary Insurance Company		
Major Medical Insurance Company		
Other Insurance (Union, Dental, Vision, etc.)		
Medicare		
Medicaid		
Workers' Compensation		
Auto Insurance		
Other insurance		

