Broome County Office of Risk & Insurance Management
Barbara J. Fiala, Broome County Executive • Robert E. Murphy, Risk Manager

Broome County Office Building • 44 Hawley Street • P.O. Box 1766 • Binghamton, New York 13902
(607) 778-2402 • Fax (607) 778-6117 • Website: www.gobroomecounty.com

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

MUST BE SIGNED FOR PAYMENT OF MEDICAL BILLS

I, ______________________________ authorize the use and disclosure of Health Information as described in this authorization.
Print Name

Specific person/organization or class of persons authorized to provide information:
Licensed physician, medical practitioner, nurse, pharmacist, hospital, clinic, other medical or medically-related facility, insurance or reinsurance company, consumer reporting agency, employer or former employer.

Specific person/organization authorized to receive and use information:
Broome County Office of Risk & Insurance and legal representatives, RMSCO, Inc. and Corporate Care Management,Inc (or current Nurse Case Management Firm)

Specific and meaningful description of the information:
Any and all office notes, diagnostic test results, x-rays, and hospital records.

Purpose of the request:
To evaluate the claim for Volunteer Firefighter Benefits, to determine causal relationship, apportionment, and possible Second Injury Fund relief.

Right to Revoke:
I understand that I have the right to revoke this authorization at any time by notifying Broome County Office of Risk & Insurance, Inc., P.O. Box 1766, Binghamton, NY 13902 in writing. I understand that this revocation is only effective after it is received and logged in by RMSCO, Inc. I understand that this revocation will not apply to any use or disclosure made prior to its activation by RMSCO, Inc.

I understand that after this information is disclosed, federal law may not protect it and the recipient may re-disclose it for the purposes stated above.

I understand that failure to sign this authorization could result in delayed processing of my claim and the Carrier’s inability to pay related medical expenses.

I understand that I may receive a copy of this authorization.

I understand that this authorization will expire when my claim for Volunteer Firefighter benefits is concluded unless revoked prior to.

Signature of Claimant: ______________________________ Date: ______________

Employer: ______________________________