

WTC VCF AUTHORIZATION



**Workers'
Compensation
Board**

World Trade Center September 11th Victim Compensation Fund (VCF) Authorization

Claimant Name *(use ink only – ballpoint pen, if possible)*

Date of Birth (MM/DD/YYYY)

Social Security Number

Mailing Address

City

State Zip

This authorization form allows the Workers' Compensation Board to obtain any information relating to my claim under the September 11th Victim Compensation Fund of 2001 (Victim Compensation Fund or VCF) from the U.S. Department of Justice for the purpose of evaluating my World Trade Center volunteer claim for compensation. This information may include, but is not limited to, medical, government and financial information about me.

I acknowledge that I have the right to revoke this authorization at any time, except to the extent that the Workers' Compensation Board has already acted based on this authorization. To revoke this authorization, send a letter to the Workers' Compensation Board at the address listed below.

Copies of this authorization that show my signature are as valid as the original release signed by me.

Signature of Claimant

Date (MM/DD/YYYY)

Printed Name

If the claimant is unable to sign, the person signing on their behalf must fill out and sign below:

Your Name

Signature

Relationship to patient

Date (MM/DD/YYYY)