Ben Walsh, Mayor

Susan R. Katzoff, Corporation Counsel

NOTICE OF CLAIM AGAINST THE CITY OF SYRACUSE

Return completed form by **CERTIFIED** or **REGISTERED MAIL** to:
Law Department, Room 300, City Hall, Syracuse, New York 13202
Service of Notice of Claim by Facsimile or E-mail is NOT acceptable.
All claims must be properly submitted in writing to the City within 90 days after claim arises.
Claims involving vehicle damage must be submitted by Registered Owner.
This form must be signed before a **NOTARY PUBLIC**.
The City Claims Department **CANNOT** provide any legal advice concerning your claim.

Mr.☐/ Ms.☐ (check one) First Name: _____Last Name(s): _____

Home Address: _____

Primary Telephone: ( ) _____(check one) Mobile ☐ Home ☐ Work ☐

Secondary Telephone: ( ) _____(check one) Mobile ☐ Home ☐ Work ☐

State when this claim arose: Month: _____Day: _____Year: _____Time___:___ am☐/ pm☐ (check one)

State the nearest address, place, or location where this claim occurred: _____

_____

State the factual nature of your claim and how it occurred in detail: _____

_____

_____

_____

_____

_____

_____

PROVIDING FALSE CLAIM INFORMATION IS PUNISHABLE AS A CRIME

The undersigned claimant attests under the penalty of perjury that the above information is correct

Date: _____ Claimant(s) Name: _____

Subscribed and sworn to before me Claimant(s) Signature: _____

this _____day of _____, 20____. (**sign only in presence of a notary public**)

_____
Notary Public

City of Syracuse Notice of Claim Supplemental Information

PROVIDING THE FOLLOWING INFORMATION MAY ASSIST IN THE PROCESSING OF YOUR NOTICE OF CLAIM:

Full Name of Claimant: _____Social Security #---------- _____

Claimant's Date of Birth: Month: _____Day: _____Year: _____

State type of bodily injuries claimed, if any: _____

_____

Name and address of health care providers seen for claimed Injuries: _____

_____

State type of property damages claims, if any: _____

_____

State total dollar value being claimed $_____State how claim value was determined and attach copies of any bills, estimates, etc.: _____

If your claim involves a motor vehicle, please provide the following information regarding your vehicle:

Year: _____Make: _____Model: _____Mileage: _____

Are you the registered owner of the motor vehicle? (check one) Yes ☐ No ☐

PLEASE PROVIDE A REPAIR ESTIMATE FOR ANY DAMAGES TO A MOTOR VEHICLE

Did you report this incident to the Police? (check one) Yes ☐ No ☐

Name of Police Department Responding: _____Report # _____

PLEASE PROVIDE A COPY OF THE INFORMATION EXCHANGE FORM PROVIDED BY THE RESPONDING POLICE DEPARTMENT

Witness Name: _____Address: _____Tel: _____

Witness Name: _____Address: _____Tel: _____

My Insurance Agent's Name: _____Tel: _____

My Insurance Company's Name: _____Tel: _____

I have made the following insurance claims within the last 10 years:

Claim Type: _____Date: _____Paid by: _____Amount: _____

Claim Type: _____Date: _____Paid by: _____Amount: _____

RELEASE OF MEDICAL RECORDS AUTHORIZATION

If seeking damages due to an alleged personal injury, claimant must fill out the HIPPA complaint Medical Records Authorization attached. ***A parent or legal guardian must sign the authorization for a claimant under 18 years of age.***

Please fill in the highlighted portions of the form.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name:	Date of Birth:	SSN:
Patient Address:		

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:

I. 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), 1 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 re-disclosing 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 re-disclosed by the recipient (except as noted above in Item 2), and this re-disclosure 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 PERSON, 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: **CITY OF SYRACUSE CORPORATION COUNSEL'S OFFICE, 300 CITY HALL, SYRACUSE, NY 13202**

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 _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with the person, attorney, or a governmental agency, listed here:

CITY OF SYRACUSE CORPORATION COUNSEL'S OFFICE, 300 CITY HALL, SYRACUSE, NEW YORK 13202

(Person, Attorney, Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
CLAIM / LITIGATION	**FINAL DISPOSITION OF CLAIM/ACTION AGAINST CITY OF SYRACUSE and/or CO-DEFENDANTS**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having H1V symptoms or infection and information regarding a person's contacts.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-complaint official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.