NOTICE OF CLAIM AGAINST THE CITY OF SYRACUSE

Note: Return completed form by **CERTIFIED/REGISTERED MAIL** to: Law Department, Room 300, City Hall, Syracuse, New York 13202.
Service of Notice of Claim by Facsimile or Email 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.

Print claimant(s) name(s): _____

Print claimant(s) home address: _____

Zip Code _____ Home Telephone ( )-_____ Work Tel. ( )-_____

State when this claim arose: Month _____ Day _____ Year _____ Time ____:____

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

_____

_____ Syracuse, NY Zip Code _____

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

this _____ day of _____, 20___.

_____
Notary Public

Rev. 12/10

CITY OF SYRACUSE NOTICE OF CLAIM SUPPLEMENTAL INFORMATION

Providing the following information may assist in the processing of your Notice of Claim:

1) Name of Claimant _____ Social Security #_____-_____-____

Claimant's Date of Birth: Month _____ Day _____ Year _____

State type of property damages claimed: _____

_____

State type of bodily injuries claimed: _____

_____

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

_____

2) Did you report this incident to the Police?_____

Name of Police Department Responding _____ Report #_____

Witness Name _____ Address_____ Tel: _____

Witness Name _____ Address _____ Tel: _____

3) (Please circle) I WILL or I WILL NOT report this claim to my insurance company.

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 _____

Name and Address of Health Care Providers Seen for Claimed Injuries: _____

_____

_____

RELEASE OF MEDICAL RECORDS AUTHORIZATION

If seeking damages due to an alleged personal injury, claimant must fill out the HIPAA compliant Medical Records Authorization attached. ***A parent or legal guardian must sign the authorization for a claimant under 18 years of age. Do not neglect to fill out section 9(a) and (b) section 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:

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), 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: **CLAIM / LITIGATION**	11. Date or event on which this authorization will expire: **FINAL DISPOSITION OF CLAIM/ACTION AGAINST CITY OF SYRACUSE or SYRACUCE CITY SCHOOL DISTRICT**
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 HIV symptoms or infection and information regarding a person's contacts.**