



GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT



Jed Ross
Chief Risk Officer

Public Sector Workers'
Compensation Program

**FORM 4-A – EMPLOYEE’S REVOCATION OF AUTHORIZATION
FOR RELEASE OF MEDICAL RECORDS**

*Use this form to revoke your prior authorization for the release of medical information in connection with your claim for workers’ compensation. **REVOCATION MAY MEAN YOUR CLAIM IS DELAYED OR DENIED.***

READ INSTRUCTIONS HERE AND ON THE REVERSE SIDE

For Help and Information, call (202) 442-HELP (4357)

IMPORTANT: Your signed Form 4 – Authorization for Release of Medical Records is necessary for your workers’ compensation claim to be deemed filed. 7 D.C.M.R. § 115.2(b). You are required to submit medical documentation to support your claim of injury, and you are required to submit documentation of medical services so the Office of Risk Management (ORM) can decide on your claim for benefits. 7 D.C.M.R. § 115.8 and 7 D.C.M.R. § 117.2. You have the burden of proof to establish entitlement to workers’ compensation. 7 D.C.M.R. § 119.1. ORM can deny a claim due to insufficient evidence or an employee’s failure to follow requirements on providing information. 7 D.C.M.R. § 120.4. **The Form 4 is a critical tool for ORM to gather medical information to determine if you are entitled to workers’ compensation. REVOKING YOUR FORM 4 MAY LEAD TO YOUR CLAIM BEING DELAYED OR DENIED.**

SECTION I. EMPLOYEE INFORMATION

Name: _____ Last Four of SSN: _____ Date of Birth: _____
Date of Injury: _____ Employee Tel.: _____
Full Address: _____
Street Address City State Zip Code

SECTION II. REVOCATION OF MEDICAL AUTHORIZATION AND RELEASE OF CONFIDENTIAL INFORMATION

I, (print name) _____, hereby revoke my authorization for the release of any and all medical reports, histories, findings, prognosis, bills, information and other documentation relating to any medical treatment or services, including psychiatric treatment or treatment for alcoholism and/or drug abuse, to the **District of Columbia Office of Risk Management (ORM), or any other agent or employee of ORM.**

SECTION III. NOTICES

I understand that despite revoking my Form 4 – Authorization for the Release of Medical Records, my medical providers may still opt to disclose medical information to ORM under the Health Insurance Portability and Accessibility Act (HIPAA) exception for workers’ compensation at 45 C.F.R. § 164.512(l)

I understand that my revocation is not effective as to medical information that has already been provided to ORM or medical information that is in transit to ORM before my revocation is processed.

I understand that revoking my Form 4 may prevent or delay processing of my workers’ compensation claim as Form 4 is required for a claim to be deemed filed. I understand that I have the burden to establish my claim for benefits, and if ORM cannot request and receive my medical records, ORM may lack sufficient evidence to render a determination.

BY REVOKING MY FORM 4, I UNDERSTAND MY CLAIM MAY BE DENIED OR TERMINATED.

SECTION IV. EMPLOYEE SIGNATURE

By my signature, I affirm that I have read and understand the foregoing provisions of this revocation. **I UNDERSTAND THE NEGATIVE IMPACTS THIS REVOCATION MAY HAVE ON MY CLAIM AND I OPT TO CONTINUE WITH REVOCATION DESPITE THESE WARNINGS.**

Signature of Employee

Date

Claimant MUST file this claim for disability by mail, e-mail, or in person with the PSWCP at the District of Columbia Office of Risk Management between the hours of 8:30 a.m. and 5:00 p.m. at:	Office of Risk Management One Judiciary Square 441 Fourth Street, N.W., Suite 800 South Washington, DC 20001-2714 Phone: (202) 442-HELP (4357) Email: wc.claims@dc.gov Fax: 202-535-1130
---	---