GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT

Jed Ross
Chief Risk Officer

Public Sector Workers' Compensation Program

FORM 15 – DECLARATION OF REPRESENTATIVE FORM

Use this form to authorize an individual to represent you before the Public Sector Workers' Compensation Program.

For Help and Information, call (202) 727-8600

SECTION I. CLAIMANT AND REPRESENTATIVE INFORMATION

Claimant's Name: _____
Claimant's Full Address:

_____
Street address

_____
City State Zip

Claimant's Tel.: _____
Claimant's E-mail: _____
Claim Number: _____

Representative Name: _____
Representative's Address: ☐ Same as Claimant

_____
Street address

_____
City State Zip

Rep.'s Tel.: _____
Rep.'s Fax: _____
Rep.'s E-mail _____

SECTION II. GENERAL AUTHORIZATION

With the exception of the acts described in Section III, I authorize my representative(s) to receive and inspect all records related to my workers' compensation claim and to perform acts that I can perform with respect to this claim. For example, my representative(s) shall have the authority to discuss matter related to my workers' compensation claim, receive and review medical records received by the Program, personnel records, and wage information.

SECTION III. HIPAA AUTHORIZATION

A. Authorization. I hereby authorize the District of Columbia's Office of Risk Management Public Sector Workers' Compensation Program to disclose the protected health information described below to my Representative identified in Section I of this Declaration.

B. Purpose. At my request for the management of all matters related to my workers' compensation claim.

C. Effective Period. This authorization for release of information covers the period of healthcare from:

☐ _____ to _____ , OR

☐ All past, present, and future periods.

D. Extent of Authorization.

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse), **OR**

☐ I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

i. This medical information may be used by my Representative to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

ii. This authorization shall be in force and effect until _____ (date or event), at which this time this authorization expires.

iii. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition for obtaining insurance coverage and the insurer has a legal right to contest a claim.

iv. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

v. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

SECTION III. NON-HIPAA EXCEPTION TO AUTHORIZATION

Unless expressly designated in this section, this authorization will allow this individual to discuss, receive and inspect your workers' compensation claim, including confidential health information, personnel records and tax information.

Specific acts not authorized.

My representative is not authorized to endorse or otherwise negotiate any check (including directing or accepting payment by any means, electronic or otherwise, into an account owned or controlled by the representative(s) or any firm or other entity with whom the representative(s) is (are) associated) issued by the government in respect of a federal tax liability.

My representative is not authorized to execute any Program required releases and affidavits. I understand that I am responsible for ensuring Program required releases and affidavits ae executed by me personally.

List any other specific deletions to the acts otherwise authorized in this Declaration of Representative:

SECTION IV. EMPLOYEE CERTIFICATION

I swear (or affirm) under penalty of perjury under the laws of the District of Columbia that I have read the foregoing Declaration and the information provided above is true and correct to the best of my knowledge. I further understand that revoke this declaration, I must submit a notarized letter to the PSWCP expressly revoking the authorization documented in this Declaration.

Signature of Employee or Representative _____ Date _____

District of Columbia

Signed and sworn to (or affirmed) before me on _____ by _____
(Date) (Claimant Name).

_____
Signature of Notarial Officer
My Commission Expires: _____

(Seal)

Claimant **MUST** file this form 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) 727-8600 E-mail: wcsecure@dc.gov**