



GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT



Jed Ross
Chief Risk Officer

Public Sector Workers'
Compensation Program

FORM 4 – EMPLOYEE’S AUTHORIZATION
FOR RELEASE OF MEDICAL RECORDS

Use this form to authorize the release of medical information, when submitting notice of work injury, and filing
claims for continuation of pay or workers’ compensation benefits.

READ INSTRUCTIONS HERE AND ON THE REVERSE SIDE
For Help and Information, call (202) 442-HELP (4357)

IMPORTANT: Employees or the representative of an employee must complete this form and submit it to the employee’s
immediate supervisor within thirty (30) days of the injury, recurrence of disability, or death. This form must be submitted
with a completed Form 1 and Form 4506-T to effectuate notice under D.C. Code § 1-623.19. Failure to timely
effectuate notice will result in denial of any claim for benefits, unless the requirements for a waiver are met under D.C.
Code § 1-623.19(b) and 7 D.C.M.R. §§ 104.5 and 104.6. Complete shaded areas.

SECTION I. EMPLOYEE INFORMATION

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

SECTION II. MEDICAL AUTHORIZATION AND RELEASE OF CONFIDENTIAL INFORMATION

I, (print name), hereby consent to, and by this authorization or any photocopy
hereof authorize, 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. This authorization shall expire automatically without express revocation at such time as my claim for benefits is
revoked, denied, or terminated.

Disclosure of medical information to the ORM is permitted under the Health Insurance Portability and Accessibility Act
(“HIPAA”). HIPAA provides: “a covered entity may disclose protected health information as authorized by and to the extent
necessary to comply with the laws relating to workers’ compensation or other similar programs, established by law, that
provide benefits for work-related injuries or illnesses without regard to fault.”45 C.F.R. § 164.51

SECTION III. EMPLOYEE SIGNATURE

By my signature, I affirm that I have read and understand the foregoing provisions of this authorization.

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: wsecure@dc.gov
Fax: 202-535-1130