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, Form F1, 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 IV. 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: wc.claims@dc.gov** **Fax: 202-535-1130**

SUBMIT THIS FORM TO YOUR IMMEDIATE SUPERVISOR AND THE ORM.