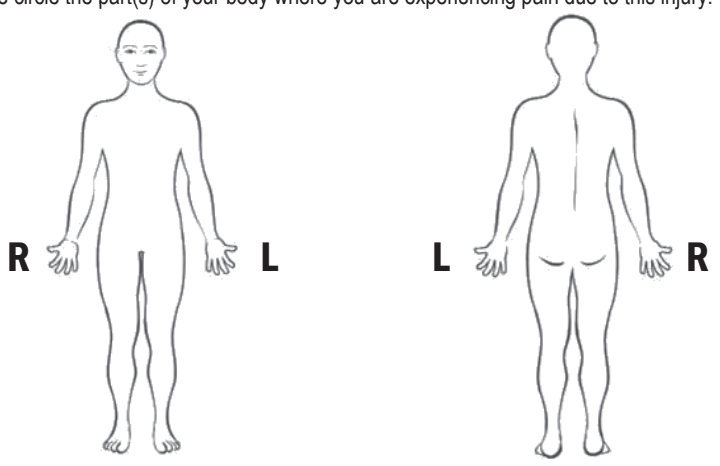


# EMPLOYEE'S INJURY REPORT

**This form must be completed in detail and signed by the injured employee.**

EMPLOYEE INFORMATION			
Your Full Name			
Employer		Location of Accident	
Social Security Number (Last 4 Digits) XXXX-XX-	Date of Birth	Department You Work For	
Your Address (Street, City, State, County, Zip)			Supervisor's Name
Phone Number Where You Can Be Reached		Job Title at Time of Injury	
Date of Hire	How Long in Current Position? _____ Yrs. _____ Months		

DETAILS OF THE INJURY		
Date of Injury	Time of Injury AM / PM	Date You First Lost Time
Where in the workplace did your injury occur?		
Describe in detail how your injury occurred.		
What safety equipment were you using at the time of the accident?		
What can be done to prevent this type of injury in the future?		

When were you first aware of this injury?	
When did you first notify your supervisor of your injury?	
What part of your body is injured?	Describe the injury.
<p>On the diagram below, please circle the part(s) of your body where you are experiencing pain due to this injury.</p> <div style="text-align: center;">  </div>	
Did anyone witness your accident? List the names of any witnesses.	
Was anyone else injured in this accident? List the names of any other injured people.	
In the incident that caused your injury, was there damage to any property or equipment? Describe any damage.	

- ✓ **I certify that the information contained in this report is true and correct.**
- ✓ **I understand that any falsification of information regarding an on the job injury may result in disciplinary action and/or prosecution under the appropriate State Criminal Statutes.**
- ✓ **I hereby authorize the release of all medical records relating to the above noted incident to my employer, his agent or insurance company.**

Employee's Printed Name	Employee's Signature	Date
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- ✓ **I certify that the above employee has acknowledged to me that he/she understood all questions and signed and dated this form in my presence this date.**

Witness Printed Name	Witness Signature	Date
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Supervisor's Printed Name	Supervisor's Signature	Date
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# HIPAA AUTHORIZATION FORM

## DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I, \_\_\_\_\_, (Name) \_\_\_\_\_, (Date of Birth) \_\_\_\_\_, (SSN) \_\_\_\_\_, authorize the disclosure of my protected health information\* as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws\*\*, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

- I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below):
  - + All healthcare providers who have provided healthcare to me.
- I authorize the following person(s) and/or organizations to receive my protected health information as disclosed by the person(s) and/or organization(s) above.
  - + Claims Administrative Services, Inc.  
P.O. Box 7500, Tyler, Texas 75711
  - + Texas Department of Insurance – Division of Workers’ Compensation  
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1609
  - + Others: \_\_\_\_\_
- Specific description of the protected health information that I authorize for disclosure:
  - + Any and all records regarding my health, including medical histories, consultations, examinations, prescriptions, diagnosis, tests, reports or treatments.
  - + I further specifically authorize the disclosure of psychotherapy notes, if any.
- The purpose for requesting this information is for use by the carrier to evaluate, adjust, describe, or report matters about my health to persons entitled to receive this information.
- I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.
- I understand that treatment and payment for my treatment are not conditioned on my agreement to this authorization.
- I understand that the release of protected health information to a non-covered entity may invalidate its protection.
- I understand that my express consent is required to release any healthcare information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use, you are specifically authorized to release all healthcare information related to such diagnosis, testing or treatment.
- This authorization expires on one year from the date of authorization, or the date that my workers’ compensation claim is finally closed, whichever occurs first.

**I have had the opportunity to read and consider the contents of this authorization. I confirm that this authorization is a true and correct statement of my intention to permit the disclosure of my PHI as described in this authorization.**

Signature	Date
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Name		
Address		
Phone Number	SSN (Last 4 Digits Only) XXX-XX-	Date of Birth

\*Protected health information (“PHI”) is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to 1) the past, present or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508 \*\*These laws apply to health plans, health care providers, and health care clearinghouses.



## **Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System**

As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel (OIEC). This assistance is offered at local offices across the State. These local offices also provide other workers' compensation system services from the Texas Department of Insurance (TDI). TDI is the State agency that administers and regulates the workers' compensation system through the Division of Workers' Compensation (DWC).

Many services provided by OIEC and DWC can be completed over the telephone. You can contact OIEC by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). Additional information, including office locations, is available on the Internet at: [www.oiec.texas.gov](http://www.oiec.texas.gov). You can contact DWC by calling the toll-free telephone number 1-800-252-7031. Information about DWC is available on the Internet at: [www.tdi.texas.gov](http://www.tdi.texas.gov).

### **Your Rights in the Texas Workers' Compensation System**

- 1. You have the right to hire an attorney to help you with your workers' compensation claim.**  
For assistance locating an attorney, contact the State Bar of Texas' lawyer referral service at 1-877-983-9227 or <http://www.texasbar.com/>. Attorney referral information can also be found on OIEC's website at [www.oiec.texas.gov](http://www.oiec.texas.gov).
- 2. You have the right to receive assistance from OIEC if you do not have an attorney.**  
OIEC Customer Service Representatives and Ombudsmen are available to answer your questions and provide assistance with your workers' compensation claim by calling OIEC or visiting an OIEC office. **You must sign a written authorization before an OIEC employee can access information on your claim.** Call or visit an OIEC office to fill out the written authorization. Customer Service Representatives and Ombudsmen are trained in the field of workers' compensation and can help you with scheduling a dispute resolution proceeding about your workers' compensation claim. An Ombudsman can also assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot make decisions for you or give legal advice.
- 3. You may have the right to receive medical and income benefits regardless of who was at fault for your injury, with certain exceptions. Your beneficiaries may be entitled to death and burial benefits.**  
Information about the exceptions can be found at [www.tdi.texas.gov](http://www.tdi.texas.gov) or by visiting with OIEC staff.
- 4. You may have the right to receive medical care to treat your workplace injury or illness for as long as it is medically necessary and related to the workplace injury.**  
You may have the right to reimbursement of your incurred expenses after traveling to attend a medical appointment or required medical examination if the trip meets qualifying conditions.
- 5. You may have the right to receive income benefits for your work-related injury.**  
There are several types of income benefits and eligibility requirements. Information on the types of income benefits that may be available and the eligibility requirements can be found at [www.tdi.texas.gov](http://www.tdi.texas.gov) or by visiting with OIEC staff.
- 6. You may have the right to dispute resolution regarding income and medical benefits.**  
You may request Medical Dispute Resolution if you disagree with the insurance carrier regarding medical benefits. You may request Indemnity (Income) Dispute Resolution if you disagree with the insurance carrier regarding income benefits. The law provides that your dispute proceedings will be held within 75 miles from your residence.
- 7. You have the right to choose a treating doctor.**  
If you are in a Workers' Compensation Health Care Network (network), you must choose your doctor from the network's treating doctor list. You may change your treating doctor once without network approval. If you are not in a network, you may initially choose any doctor who is willing to treat your workers' compensation injury; however,

changing your treating doctor must be pre-approved by the DWC if you are not in a network. If you are employed by a political subdivision (e.g. city, county, school district,) you must follow its rules for choosing a treating doctor. It is important to follow all the rules in the workers' compensation system. **If you do not follow these rules, you may be held responsible for payment of medical bills.** OIEC staff can help you to understand these rules.

**8. You have the right for your workers' compensation claim information to be kept confidential.**

In most cases, the contents of your claim file cannot be obtained by others. Some parties have a right to know what is in your claim file, such as your employer or your employer's insurance carrier. Also, an employer that is considering hiring you may get limited information about your claim from DWC.

**Your Responsibilities in the Texas Workers' Compensation System**

- 1. You have the responsibility to tell your employer if you have been injured at work while performing the duties of your job. You must tell your employer within 30 days of the date you were injured or first knew your injury or illness might be work-related.**
- 2. You have the responsibility to know if you are in a Workers' Compensation Health Care Network (network).**

If you do not know whether you are in a network, ask the employer you worked for at the time of your injury. If you are in a network, you have the responsibility to follow the network rules. If there is something you do not understand, ask your employer or call OIEC. If you would like to file a complaint about a network, call TDI's Customer Help Line at 1-800-252-3439 or file a complaint online at <http://www.tdi.texas.gov/consumer/complfrm.html#wc>.
- 3. If you worked for a political subdivision (e.g., city, county, school district) at the time of your injury, you have the responsibility to find out how to receive medical treatment.**

Your employer should be able to provide you with the information you will need in order to determine which health care providers can treat you for your workplace injury.
- 4. You have the responsibility to tell your doctor how you were injured and whether the injury is work-related.**
- 5. You have the responsibility to send a completed Employee's Claim for Compensation for a Work-Related Injury or Occupational Claim Form (DWC041) to DWC.**

You have one year to send the form after you were injured or first knew that your illness might be work-related. Send the completed DWC041 form even if you already are receiving benefits. You may lose your right to benefits if you do not timely send the completed claim form to DWC. For a copy of the DWC041 form you may contact DWC or OIEC.
- 6. You have the responsibility to provide your current address, telephone number, and employer information to DWC and the insurance carrier. DWC can be contacted at 1-800-252-7031.**
- 7. You have the responsibility to tell DWC and the insurance carrier anytime there is a change in your employment status or wages.** (Examples of changes include: you stop working because of your injury; you start working; or you are offered a job).
- 8. Eligible beneficiaries or persons seeking death and burial benefits have the responsibility to send a completed Beneficiary Claim for Death Benefits (DWC-042) to DWC within one year following the employee's date of death.**
- 9. You are prohibited from making frivolous or fraudulent claims or demands.**