DIVISION OF WORKERS' COMPENSATION

CLAIMANT AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

1. I _____ authorize the use or disclosure of my workers' compensation records that are described below in paragraphs three and five.
   The last four digits of my social security number are XXX-XX-_____.
2. The following individual or organization is authorized to make the disclosure:

   Missouri Department of Labor and Industrial Relations – Division of Workers' Compensation

   Address: P.O. Box 58, Jefferson City. MO 65102-0058
3. The type of records and information to be used or disclosed is as follows. **Please strike through all records that should not be disclosed**:

   Any and all records concerning all injuries reported to the Division of Workers' Compensation, including, but not limited to, reports of injury, employer's report of injury or accident, supplemental records, medical records, administrative records and claims filed, wage statements, transcripts of any and all hearings, awards, records of benefits paid, minute sheets, rehabilitation forms, medical fee dispute filings, stipulations for compromise settlement with exhibits or addendums including information that is confidential under federal or state laws, and all other documents in the possession of the Missouri Division of Workers' Compensation regarding all current and prior injuries or claims for workers' compensation benefits.
4. I am restricting the release of records for a certain period which is from _____ to _____.
5. I understand that the information in my workers' compensation records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

   ☐ My initials specifically authorize disclosure of such records

   ☐ My initials do not authorize disclosure of such records
6. The records may be disclosed to and used by the following individual or organization:

   _____

   Address: _____

   For the purpose of: _____
7. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present any written revocation to the Division of Workers' Compensation. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in ONE YEAR from the date of execution.
8. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I understand I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Claimant or Legal Representative (if claimant is deceased, a minor, or incapacitated) Date

_____ _____
Printed Name of Claimant or Legal Representative (if claimant is deceased, a minor, or incapacitated) Claimant's Date of Birth

_____
Claimant Address

_____
If signed by Legal Representative, relationship to Claimant Date

Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711

A PHOTOCOPY OF THIS RELEASE IS VALID AS ORIGINAL

STATE OF MISSOURI)

COUNTY OF)

Subscribed and sworn to before me this _____day of _____, 20___.

_____

Notary Public

My Commission Expires:

(Notarial Seal)