



INTAKE PACKET

Please fill out the entire Intake Packet so the Office of Injured Employee Counsel (OIEC) can start helping you.

- Intake Form (Complete, sign and date.)
Treatment and Other Claim Information Form (It is important that you provide the information for all doctors/hospitals/clinics who have treated you - first and last name, address, and phone and fax number.)
OIEC-31, HIPAA Authorization (Complete, sign, date.)
OMB-02, Office of Injured Employee Counsel Assistance Request (Complete, sign and date.)

Print to sign all forms and send by fax or mail:
Office of Injured Employee Counsel
7551 Metro Center Drive, Suite 100, MS-50, Austin, TX 78744
Fax number (512) 804-4181

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INTAKE FORM
Last name: First name: Last 4 social security numbers: xxx-xx- ____
Phone number: Email address:
Mailing address: Mailing address - city, state, zip code:
DWC #: Date of injury: Employer at time of injury:
Are you working? Yes No Were you working for any other employer when you were injured?
If not, when did you stop? Yes, (employer name) No
Insurance carrier: Treating doctor:
Have you been examined by a doctor who assigned an impairment rating? Are you a candidate for surgery? If so what kind?
Yes, (doctor name) No Yes, (surgery type) No
Tell us how you were injured. What type of assistance are you requesting from OIEC? Please provide as much information as possible.
The information in this Intake Form is accurate to the best of my knowledge. By signing this form, I authorize the Office of Injured Employee Counsel to submit documents to the Division of Workers' Compensation on my behalf.
I accept and do authorize the Office of Injured Employee Counsel to send text messages to my cell phone.
Cell Phone Number: Cell Phone Provider (AT&T, T-Mobile, Sprint, etc.):
Employee signature: Date:
OIEC STAFF ONLY
Reviewed by CHL OMB-2 DAL DCL DWC32 DWC45 SCN I12 ADMIN-14



TREATMENT AND OTHER CLAIM INFORMATION FORM

LIST OF DOCTORS, HOSPITALS, OR CLINICS

Please include names, addresses, phone numbers and fax numbers of all medical providers, including therapy treatments, hospitals and testing facilities that you have treated with for this workers’ compensation injury.

Check here if you have never been seen by a doctor for your injury.

Doctor/hospital/clinic name 1	
Address	
Telephone number	
Fax number	
Doctor/hospital/clinic name 2	
Address	
Telephone number	
Fax number	
Doctor/hospital/clinic name 3	
Address	
Telephone number	
Fax number	
Doctor/hospital/clinic name 4	
Address	
Telephone number	
Fax number	
ADDITIONAL CLAIM INFORMATION	
Referral Doctor(s)	
Treatment(s) Received:	<input type="checkbox"/> Medication <input type="checkbox"/> MRI <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Injections <input type="checkbox"/> Nerve Study (EMG/NCV) <input type="checkbox"/> Surgery
Adjuster’s name	
Adjuster’s phone number	
Adjuster’s fax number	
Attorney’s name/phone number (if any)	
<i>Please note – if you represented in the workers’ compensation claim, OIEC cannot be involved or assist.</i>	
Average Weekly Wage	



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last _____ First _____ Middle _____

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

CITY, STATE, ZIP _____

PHONE _____ ALT. PHONE (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION (please list below):

Person/Organization Name: SEE LIST OF MEDICAL PROVIDERS ATTACHED

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Organization Name: **OFFICE OF INJURED EMPLOYEE COUNSEL**
Address: **7551 METRO CENTER DRIVE, SUITE 100**
City, State, Zip Code: **AUSTIN, TX 78744**
Phone: (866) 393-6432
Fax: (512) 804-4181

REASON FOR DISCLOSURE (Choose only one option below)

- Treatment/Continuing Medical Care
- Personal Use
- Billing or Claims
- Insurance
- Legal Purposes
- Disability Determination
- School
- Employment
- Other - **Workers' Compensation**

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> All health information | <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Past/Present Medications | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Patient Allergies | <input type="checkbox"/> Operation Reports | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Diagnostic Test Reports | <input type="checkbox"/> EKG/Cardiology Reports |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Billing Information | <input type="checkbox"/> Radiology Reports & Images | <input type="checkbox"/> Other _____ |

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes) _____ Genetic Information (including Genetic Test Results)
_____ Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE ⇒ _____
Signature of Individual or Individual's Legally Authorized Representative _____ **DATE** _____

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: Parent of minor Guardian Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE _____
Signature of Minor Individual _____ **DATE** _____

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §§ 181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii)); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)).

Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.



OFFICE OF INJURED EMPLOYEE COUNSEL ASSISTANCE REQUEST

Name: _____

DWC#: _____

Address: _____

Email address: _____

City: _____

Date of injury: _____

Telephone: _____

I, _____, am requesting the assistance of the Office of Injured Employee Counsel (OIEC). I am not represented by an attorney on the issue for which I am requesting assistance, although I know that I have that right. This document will remain in effect until I terminate it. I may terminate OIEC assistance at any time by notifying the Office of Injured Employee Counsel or by hiring an attorney. If I hire an attorney, I know that my attorney must file his or her contract of employment with the Texas Department of Insurance, Division of Workers' Compensation.

I know and clearly understand that the Ombudsman:

- is an employee of the Office of Injured Employee Counsel.
- is not acting as an attorney nor performing services of an attorney.
- will not be representing me as an attorney or in any other capacity.
- will be assisting me to present my claim for benefits.
- provides assistance at no charge to unrepresented persons requesting assistance.
- cannot and will not provide legal advice.
- cannot and will not make or sign any agreements for me.
- cannot and will not make any decisions for me.

I authorize any OIEC employee to have access to my claim file and other confidential records pertaining to my claim, including medical records.

I understand that any communication made to any OIEC employee is confidential under Texas Labor Code § 404.110 and that the employee cannot generally be compelled to disclose that information on any matter relating to my workers' compensation claim.

I authorize the Ombudsman to sign documents on my behalf that are required to be filed to preserve my rights in the workers' compensation system.

I have read or have had this information read to me by someone of my choice, and I understand and accept these terms.

Signature of Injured Employee or Beneficiary

Date

NOTE: With few exceptions, upon your request, you are entitled to be informed about the information the Office of Injured Employee Counsel collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have the Office of Injured Employee Counsel correct information that is incorrect (Government Code, §559.004).