EMPLOYEE'S INJURY REPORT

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

EMPLOYEE INFORMATION

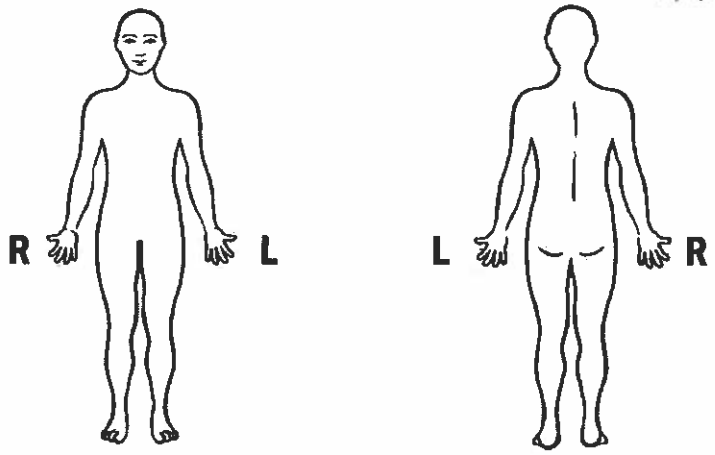
Your Full Name			
Employer		Location of Accident	
Social Security Number (Last 4 Digits)	Date of Birth	Department You Work For	
Your Address (Street, City, State, County, Zip)		Supervisor's Name	
Phone Number Where You Can Be Reached		Job Title at Time of Injury	
Date of Hire		How Long in Current Position?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

On the diagram below, please circle the part(s) of your body where you are experiencing pain due to this injury.



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

✓ **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

Supervisor's Printed Name	Supervisor's Signature	Date

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.

1. 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.**
2. 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:** _____
3. 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.**
4. 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.
5. 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.
6. I understand that treatment and payment for my treatment are not conditioned on my agreement to this authorization.
7. I understand that the release of protected health information to a non-covered entity may invalidate its protection.
8. 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.
9. 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**

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.