

District Name:

Granbury ISD

IMPORTANT NOTICE TO MEDICAL PROVIDER

INSTRUCTIONS: This form should be given to the injured worker to present to the medical care provider from whom s/he seeks treatment for work-related injury. Please print all information.

SECTION I: Incident Information

Name of Injured Employee:
Date, Day-of-the-Week, and Time of Incident:
Specific Body Part(s) Affected by this Incident:
Detailed Description of Incident:

DEAR MEDICAL CARE PROVIDER:

The above named employee has reported a work-related injury incident. Our district is a tax-supported public entity, and as such is Self-Insured for the purposes of Workers= Compensation. Our district DOES have a light-duty program. This may allow the injured worker to return to work with restrictions as specified by you with no lost wages to the injured employee. Please supply the injured worker with a **DWC-73 Division of Worker's Compensation Work Status Report** upon completion of initial treatment and evaluation of the injured workers= condition. Thank You.

IMPORTANT HIPAA INFORMATION: Since the implementation of HIPAA regulations, our district has heard concerns from a number of medical providers regarding the release of medical records without specific patient consent, even though it is clear that the information is to be used for workers= compensation utilization and billing issues. Workers= Compensation injuries are specifically excluded from HIPAA regulations, and as a result, no patient consent form is required to release medical information. (Texas Workers= Compensation Commission Advisory 2003-05)

However, as a service to medical providers, we are supplying a Release of Medical Records consent signed by the injured worker. See below. This statement, when signed by the injured worker, releases medical records to the District and Creative Risk Funding (our TPA) for the purpose of managing the claim under Texas Department of Insurance, Division of Workers' Compensation rules.

RELEASE OF MEDICAL RECORDS AUTHORIZATION

I hereby authorize the physician/medical provider to disclose any information to my employer and employer=s agents regarding treatment for my work-related injury. I hereby release the physician/medical provider from any liability arising from such disclosure regarding this and any subsequent follow-up treatment.

Employee Signature

Date

SchoolComp - Self Insured Workers= Compensation Program

Administered by **Creative Risk Funding, Inc.**

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