Office of Injured Employee Counsel

7551 Metro Center Drive, Suite 100, Austin, TX 78744
F: (512) 804-4181 | T: (866) 393-6432
E: oiecinbox@oiec.texas.gov

INTAKE FORM

REQUIRED FORMS

☐ **OIEC-31, HIPAA Authorization** *(Complete, sign, date. It is important that you provide the information for all doctors who have treated you – first and last name, address, and phone and fax number.)*

☐ **OMB-02, Office of Injured Employee Counsel Assistance Request** *(Complete, sign and date.)*

ABOUT YOU

Last name:	First name:	Your phone number:

Last 4 social security numbers: XXX-XX- _ _ _ _	Your street address:
Your email address:	Your address - city, state, zip code:

ABOUT YOUR CLAIM

DWC #:	Date of injury:
Insurance carrier:	Employer at time of injury:
Adjuster's name:	Were you working for any other employer when you were injured? ☐ Yes, (employer name) _____ ☐ No
Adjuster's phone number:	*Attorney's name (if any): **If the claimant is represented, OIEC cannot be involved or assist.*
Adjuster's fax number:	*Attorney's phone number (if any):

ABOUT YOUR BENEFITS

Average Weekly Wage:	Treating Doctor:
Are you working? If not, when did you stop?	Referral Doctor(s):
Why did you stop working?	Treatment(s) Received: ☐ Medication ☐ MRI ☐ Physical Therapy ☐ Injections ☐ Nerve Study (EMG/NCV) ☐ Surgery
Have you been examined by a doctor who assigned an impairment rating? ☐ Yes, (doctor name)_____ ☐ No	Are you a candidate for surgery? If so what kind? ☐ Yes, (surgery type)_____ ☐ No

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DWC # _____

ABOUT YOUR INJURY

Tell us how you were injured? Please provide as much information as possible.

ABOUT YOUR DISPUTE

What type of assistance are you requesting from OIEC?

SIGNATURE

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

Mail or fax the completed intake form and attached forms to:
Office of Injured Employee Counsel
7551 Metro Center Drive, Suite 100, MS-50, Austin, TX 78744
Fax number (512) 804-4181

MEDICAL PROVIDERS

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

Doctor name	
Address	
Telephone number	
Fax number	
Doctor name	
Address	
Telephone number	
Fax number	
Doctor name	
Address	
Telephone number	
Fax number	
Doctor name	
Address	
Telephone number	
Fax number	
Doctor name	
Address	
Telephone number	
Fax number	

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.

- ☒ **All health information**
- ☒ Physician's Orders
- ☒ Progress Notes
- ☒ Pathology Reports
- ☒ History/Physical Exam
- ☒ Patient Allergies
- ☒ Discharge Summary
- ☒ Billing Information
- ☒ Past/Present Medications
- ☒ Operation Reports
- ☒ Diagnostic Test Reports
- ☒ Radiology Reports & Images
- ☒ Lab Results
- ☒ Consultation Reports
- ☒ EKG/Cardiology Reports
- ☒ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ 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

"Our mission is to assist, educate, and advocate on behalf of the injured employees of Texas."

E: oiecinbox@oiec.texas.gov | T: 866.393.6432

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 time-sensitive 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).

Form OMB-02 (Rev. 03/2017)

SAVE PRINT