SORM
STATE OFFICE *of* RISK MANAGEMENT

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient:_____

TO WHOM IT MAY CONCERN:

You are hereby expressly authorized to release and furnish to the State Office of Risk Management (SORM), and/or any associate, assistant, representative, agent, or employee thereof, any and all desired information (including, but not limited to, office records, medical reports, memos, hospital records, laboratory reports, including results of any and all tests including alcohol and/or drug tests, X-rays, X- ray reports, including copies thereof) pertaining to the physical and/or mental condition which is the basis of my workers' compensation claim. This includes not only all current and/or future information but also all past medical information which is related to the injury or injuries which form the basis of my claim.

(Print name)_____

Photostatic copies of this signed authorization will be considered as valid as the original.

This is not a release of claims for damages.

SIGNED:_____ DATED:_____

PLEASE SIGN THE ABOVE MEDICAL AUTHORIZATION AND RETURN IT, SO WE MAY SECURE RELEASE OF YOUR MEDICAL RECORDS.

THANK YOU.

STATE OFFICE *of* RISK MANAGEMENT

Instructions
Authorization for Release of Information

Required:

This document is required immediately after sustaining a work-related injury. The injured employee should complete this release form. This enables SORM to obtain, from healthcare providers, copies of relevant medical documents that will assist in the handling of the claim.

Filing Deadline:

The form must be received by SORM not later than the **5th calendar day** after the first notice of injury is reported to the agency.

Completed by:

The employee must complete this form. If the employee is incapacitated the spouse, child, or legal guardian may sign the form. **THIS FORM MUST BE SIGNED AND DATED.** The Claims Coordinator should make this form available for all injuries.

Instructions:

1. The injured employee must clearly print his or her name on the patient line.
2. The injured employee must clearly print his or her name on the second line.
3. The injured employee must sign and date the form.

Distribution:

The Claims Coordinator shall retain the original for the agency file and fax or mail a copy to:

State Office *of* Risk Management
PO Box 13777
Austin, TX 78711
Fax: (512) 370-9025

Notice: With few exceptions, an individual is entitled, upon request, to be informed about the information a state governmental body collects about the individual. Under Sections 552.021 and 552.023 of the Government Code the individual is entitled to receive and review the information and under Section 559.004 of the Government Code the individual is entitled to have the state governmental body correct any information about the individual that is incorrect.