STATE OF MISSOURI
OFFICE OF ADMINISTRATION
RISK MANAGEMENT SECTION

AUTHORIZATION TO RELEASE MEDICAL RECORDS - WORKERS' COMPENSATION

CENTRAL ACCIDENT REPORTING OFFICE (CARO)
P.O. BOX 809
JEFFERSON CITY, MO 65102
573-751-2837
TOLL FREE 1-888-622-7694

To Whom It May Concern:

I, the undersigned, _____ ,
PRINT OR TYPE NAME

_____ , do hereby request and authorize any medical health care provider, upon presentation
DATE OF BIRTH

of this authorization, to disclose to the State of Missouri, Central Accident Reporting Office, or its representative, including the Attorney General of Missouri and his Assistants, any material or information concerning _____ with respect to illness or injury,
PRINT OR TYPE NAME

medical history, consultation, treatment including but not limited to x-rays, medical histories, nurses' notes, prescriptions and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

This is not a release of any claim I may have.

SIGNED	DATE

STREET ADDRESS	TELEPHONE

CITY	STATE	ZIP CODE

STATE OF MISSOURI
OFFICE OF ADMINISTRATION
RISK MANAGEMENT SECTION

WORKERS' COMPENSATION DISABILITY LEAVE OPTIONS

CENTRAL ACCIDENT REPORTING OFFICE (CARO)
P.O. BOX 809
JEFFERSON CITY, MO 65102
573-751-2837

EMPLOYEE'S NAME (LAST, FIRST, MI)	DATE OF INJURY	CARO NUMBER

I understand that I have the following options available to me while I am unable to work due to a work-related injury covered by workers' compensation.

CHECK ONE:

☐ I elect to receive workers' compensation temporary total disability benefits for my lost time calculated at sixty-six and two-thirds percent of my average weekly wage not to exceed the maximum set by law. I understand I may request to use my accumulated vacation and/or accumulated compensatory time which may be approved, and there will be no reduction in my workers' compensation temporary total disability benefits.

EFFECTIVE DATE

☐ I elect to have my accumulated sick leave applied to my lost time in lieu of receiving workers' compensation temporary total disability benefits without affecting my right to medical and permanent disability benefits, if any. If the sick leave option is selected, workers' compensation temporary total disability benefits as provided by law may begin as soon as my sick leave balance is depleted or I change my option.

EFFECTIVE DATE

After choosing one of the above described options, I have the right to file a revision of this form changing my option. The change will become effective on or after the date I sign the revised form.

EMPLOYEE'S SIGNATURE	DATE OF SIGNATURE
WITNESSES SIGNATURE	DATE OF SIGNATURE