



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,  
 \_\_\_\_\_, DATE OF BIRTH, do hereby request and authorize any medical health care provider, upon presentation 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 \_\_\_\_\_ PRINT OR TYPE NAME with respect to illness or injury, 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 |