TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION
7551 Metro Center Drive, Suite 100
Austin, TX 78744

SUBMIT A SEPARATE DWC FORM-153 FOR EACH DWC OR IAB #

REQUEST FOR COPIES OF CONFIDENTIAL CLAIMANT INFORMATION

Please carefully read the information on both sides of this form and the accompanying Instructions. INCORRECTLY COMPLETED FORMS WILL BE RETURNED TO REQUESTOR WITHOUT ACTION. This form must be signed by a party eligible to receive the information requested. Additional documentation may be required for eligibility. The signature must be notarized.

(Please type or print)

I. CLAIM FILE IDENTIFICATION. Provide the following information to identify the requested claim file.

DWC or IAB Number		Employee's Social Security Number (last 4)	X X X – X X –
Employee's Name		Employee's Date of Injury	m m – d d – y y y y
Last	First MI		
Address	City	State	Zip Code

II. REQUESTOR INFORMATION. Provide the following information pertaining to the requestor.

Name	**RECORDS DEPOSITION SERVICE, INC.**	DWC/Representative Box No. (If Applicable):	
Address	**PO BOX 5054**	E-mail Address:	
City, State	**SOUTHFIELD, MI**	ZIP **48086-5054**	Telephone No. **248.357.3330** / Fax No. **248.357.3337**

III. INFORMATION REQUESTED. Please indicate the information and services requested. Service consists of paper copies of claim information maintained in paper and/or electronic format within the following areas of the Division of Workers' Compensation files.

☐ Claim File ☐ Certified ☐ Uncertified

- ☐ Dispute Resolution Contact Data (electronic)
- ☐ Complete File
- ☐ Specific Document in File:_____

☐ Medical Dispute Resolution File (after 1/1/91) ☐ Certified ☐ Uncertified

Tracking No: _____

- ☐ Medical Dispute Resolution Contact Data (electronic)
- ☐ Complete File
- ☐ Specific Document in File:_____

☐ Indemnity Dispute Resolution File (claims with a date of injury after 1/1/91 only). ☐ Certified ☐ Uncertified

DWC Docket No: _____

- ☐ Complete File
- ☐ Specific Document in File:_____
- ☐ Video Tape (if available) ☐ CD (if available) ☐ Audio Tape (if available)
- ☐ Tape Transcription: Hourly Rate

Any questions about a specific file should be directed to the area maintaining the file.

ALL PAGES MUST BE COMPLETED

IMPORTANT: BY EXECUTING THIS FORM, REQUESTOR REPRESENTS THAT HE OR SHE IS ENTITLED TO THE INFORMATION REQUESTED AND HAS FULL AUTHORITY TO ACT AS A REQUESTOR. REQUESTOR ALSO ACKNOWLEDGES LIABILITY FOR PAYMENT OF ALL AMOUNTS OWED FOR SERVICES PROVIDED AS A RESULT OF THIS REQUEST.

IV. REQUESTOR ELIGIBILITY AND NOTARIZATION. (PLEASE CHECK ONE BOX ONLY)

The Texas Workers' Compensation Act, Texas Labor Code, Title 5, Section 402.084, limits the release of confidential information in or derived from a claim file to the categories of persons listed below. Indicate the category of eligibility, which qualifies you to receive the information requested. Sign and complete the notarization prior to sending the request to the Texas Department of Insurance (TDI) Division of Workers' Compensation (DWC). Eligibility will be verified by TDI DWC.

- [X] The employee or the employee's legal beneficiary (ATTACH DOCUMENTATION)
- [ ] The employee's or the legal beneficiary's representative (ATTACH DOCUMENTATION)
- [ ] The employer at the time of injury. Requestor must provide injured employee's period of employment: (ATTACH DOCUMENTATION)

  _____ mo./yr to _____ mo./yr.
- [ ] The Texas Certified Self-Insurer Guaranty Association Established under Subchapter G, Chapter 407, if that association has assumed the obligations of an impaired employer.
- [ ] The insurance carrier or insurance carrier's legal counsel/representative. (ATTACH DOCUMENTATION)
- [ ] The Texas Property and Casualty Insurance Guaranty Association, if that association has assumed the obligations of an impaired insurance company
- [ ] A third party litigant in a lawsuit, in which the cause of action arises from the incident that gave rise to the injury. (COPY OF PETITION AND ANSWER MUST BE ATTACHED). Requestor must provide injured employee's date of injury _____ mo/yr
- [ ] Health Care Provider who is a party to a Medical Dispute (Section 413.031 of the Act)

I have read and understand this form and the accompanying instructions. **I am entitled** to receive the confidential employee information being requested as indicated above. **I understand** that it is a Class A misdemeanor to unlawfully receive, publish, disclose, or distribute confidential information in or derived from an employee's claim file. [Texas Labor Code, Sections 402.064; 402.081; 402.083 - .084; 402.086 and 402.091]

Name of Requestor: _____
(Please Print)

Position/Title: _____

Firm Name: _____
(if applicable)

Federal Tax I.D.#: _____

Signature: _____ _____
Date

State of _____ *
*
County of _____ *

Before me on the above date personally appeared _____,
who after first being sworn or affirmed, said that the statements contained in this request are true.

Signed _____

Notary Public, State of _____

My Commission Expires _____