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) -- --
Employee's Name Last First MI	Employee's Date of Injury -- -- m m d d y y y y
Address City State Zip Code	

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

Name		DWC/Representative Box No. (If Applicable):	
Address		E-mail Address:	
City, State	ZIP	Telephone No. ( )	Fax No. ( )

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: __________________

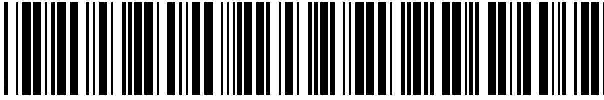
- ☐ Medical Dispute Resolution Contact Data (electronic)
- ☐ Complete File
- ☐ Specific Document in File:_______________________

☐ 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.

] 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

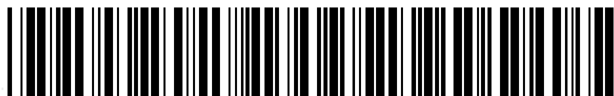
State of ____________________ *
*
County of ____________________ *

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 ____________________



REQUEST FOR COPIES OF CONFIDENTIAL CLAIMANT INFORMATION INSTRUCTIONS (DWC FORM-153)

1. **DWC FORM-153 MUST BE COMPLETED IN ITS ENTIRETY.** Please print or type. Submit a separate DWC FORM- 153 request form for each DWC claim number for which you are requesting copies. **We do not accept faxed or emailed copies.** We do not release claimant information except as provided by law.
2. Section II (Requestor Information) includes a space for an e-mail address. The e-mail address is requested so that TDI may process the request expeditiously, obtain additional information to complete verification and for billing purposes. The e-mail address is made confidential under TEX. GOV'T CODE ANN. § 552.137 and will not be released without your affirmative consent.
3. A requestor MUST indicate in Section IV the legal basis on which he/she is **eligible** to receive requested confidential employee information. Only individuals in the categories listed are entitled to receive copies of confidential information. See, Texas Workers' Compensation Act, Texas Labor Code, Section 402.084. See TDI's website for additional information. Additional documentation required for eligibility.
   A. An eligible insurance carrier must have handled a workers' compensation claim for the injured worker.
   B. An out of state insurance carrier or employer, or their legal representative, may be eligible to receive confidential claim file information. Documentation of a workers' compensation claim against that employer or the insurance carrier paying that claim must be provided to determine eligibility.
4. A lay person or a legal representative may represent a claimant or a claimant beneficiary. Other parties eligible to receive confidential claim file information may authorize a legal representative to request and receive the information on their behalf. To establish eligibility to receive confidential claim file information, the legal representative of a party must provide documentation of representation, e.g. letter of representation from client, copy of the contract between the client and the representative or the defendant's original answer.
5. The requestor must swear or affirm to the correctness of the entitlement information before a **notary public**, sign the completed form before the notary, and have the notary complete the acknowledgment. The original signed and notarized form should be mailed or personally delivered to the address indicated at top of DWC FORM-153. Incorrectly attested forms will be returned without action.
6. **Copies of this form** will be accepted if **both** sides are an exact reproduction of the original and include an original signature and notarization.
7. Indicate if a **certified copy** is requested. The copy of the information requested will have a letter of certification attached, which is signed or stamped and sealed by the Custodian of Records, or their delegate, attesting to the authenticity of the attached document(s). See Section III. Certifications are an additional $1.00 fee each.
8. **Charges and billing will be as follows:**
   A. **Charges exceeding $40 will require approval and estimates over $100 will require a deposit before documents can be provided/mailed. TDI Agency Counsel will send an itemized statement after the documents are mailed. Questions regarding billing should be directed to TDI Agency Counsel.**
   B. Make checks payable to the Texas Department of Insurance.
9. No priority mailing is available unless the requestor provides an account number.
10. For **additional assistance** in completing this form call the area that maintains the file requested. Records Center file call (512) 804-4990 x354 or x355; Medical Dispute Resolution file call (512) 804-4812; Indemnity Dispute Resolution file call (512) 804-4060.
11. A cancellation of a request must be in writing, call the TDI Agency Counsel section at (512) 475-1757 or one of the above-listed areas. Cancellation will **NOT** relieve requestor of responsibility for payment of amounts owed for services provided PRIOR to notice of cancellation. Any questions regarding billing should be directed to TDI Agency Counsel at (512) 463-6434.

GOVERNMENTAL AGENCIES/POLITICAL SUBDIVISIONS OR REGULATORY BODIES requesting copies of confidential claimant information in a capacity other than as an employer, should not complete this form. Please contact DWC Legal Services at (512) 804-4275 for information concerning determination of eligibility to receive confidential information.

IMPORTANT: BY EXECUTION OF DWC FORM-153, THE REQUESTOR REPRESENTS THAT HE OR SHE IS ENTITLED TO THE INFORMATION REQUESTED AND THAT HE OR SHE HAS FULL AUTHORITY TO ACT AS A REQUESTOR. IT IS A CLASS A MISDEMEANOR FOR UNAUTHORIZED PERSONS TO RECEIVE CONFIDENTIAL CLAIM FILE INFORMATION OR TO DISCLOSE SUCH INFORMATION TO UNAUTHORIZED PERSONS (TEXAS LABOR CODE §§ 402.064; 402.081; 402.083 - .084; 402.086 & 402.091). THE REQUESTOR ALSO ACKNOWLEDGES LIABILITY FOR PAYMENT OF ALL AMOUNTS OWED FOR SERVICES PROVIDED AS A RESULT OF THIS REQUEST.