



# DISCOVERY USES & ABUSES

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# Subpoena Duces Tecum of Medical Report & Testimony: Consulting Expert is Work Product until Disclosed

**MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS**  
**WORKERS' COMPENSATION**  
 AUTHORIZATION TO INSPECT AND/OR COPY MEDICAL RECORDS

3315 W. Truman Blvd.  
 P.O. Box 58  
 Jefferson City, MO 65102-0058  
 873-781-4241  
[www.labor.mo.gov/DWCR](http://www.labor.mo.gov/DWCR)

Injury Number \_\_\_\_\_ Checked By \_\_\_\_\_

TO: \_\_\_\_\_

Employee \_\_\_\_\_ Employer \_\_\_\_\_

Insurer \_\_\_\_\_ Date of Accident \_\_\_\_\_

Place and County of Accident \_\_\_\_\_

Description of Injury (Must include part of body affected) \_\_\_\_\_

You are hereby authorized to permit \_\_\_\_\_  
 in behalf of \_\_\_\_\_ (PARTY) \_\_\_\_\_ and all medical  
 records you have in your possession in regard to the above captioned  
 Division of Workers' Compensation.

**NOTE:** The medical records which may be released according to  
 treatment for the injury suffered on the date of accident;  
 the injury listed above, as to the type of injury and if  
 Medical records from before the date of accident or  
 do not relate to this injury, may not be released pur

This authorization is made in accordance with Section 287  
 "Every hospital or other person furnishing the empl  
 cepted by and shall furnish full information to the  
 employee or his dependents and any other party"  
 and certified copies of the records shall be adm

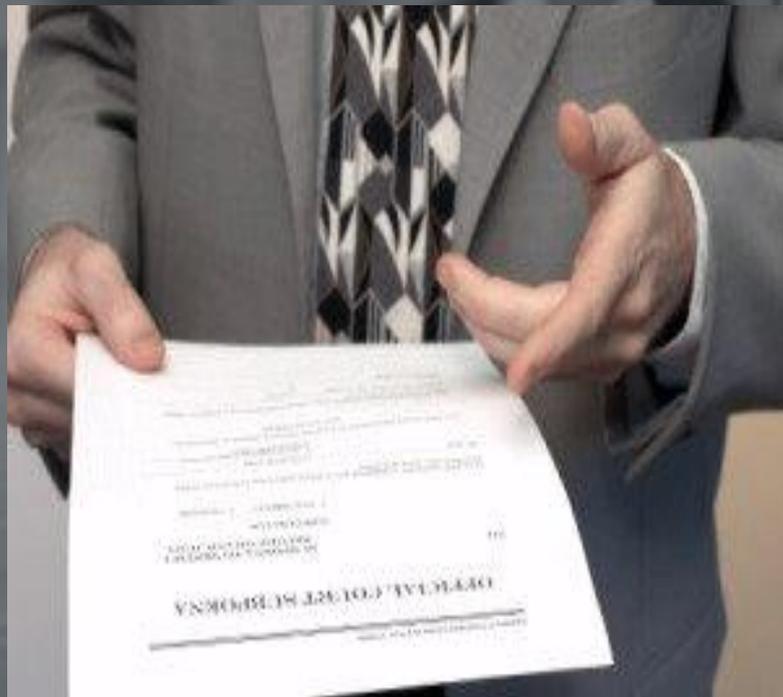
Date \_\_\_\_\_ AP

*This form is effective twelve months*



# Employee CANNOT be Forced to Sign Medical Authorizations





Subpoena Duces Tecum *without* Notice is Inappropriate, as is cover letter instructing Deposition will be cancelled if records are produced (without consent of all counsel)

# Medical Exam/Psychological Exams



# Unemployment Records



# Division Files for Prior Injuries



## CLAIMANT AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

- I \_\_\_\_\_ authorize the use or disclosure of my workers' compensation records that are described below in paragraphs three and five.  
The last four digits of my social security number are XXX-XX-\_\_\_\_\_.
- The following individual or organization is authorized to make the disclosure:  
Missouri Department of Labor and Industrial Relations – Division of Workers' Compensation  
Address: P.O. Box 58, Jefferson City, MO 65102-0058
- The type of records and information to be used or disclosed is as follows. **Please strike through all records that should not be disclosed:**  
Any and all records concerning all injuries reported to the Division of Workers' Compensation, including, but not limited to, reports of injury, employer's report of injury or accident, supplemental records, medical records, administrative records and claims filed, wage statements, transcripts of any and all hearings, awards, records of benefits paid, minute sheets, rehabilitation forms, medical fee dispute filings, stipulations for compromise settlement with exhibits or addendums including information that is confidential under federal or state laws, and all other documents in the possession of the Missouri Division of Workers' Compensation regarding all current and prior injuries or claims for workers' compensation benefits.
- I am restricting the release of records for a certain period which is from \_\_\_\_\_ to \_\_\_\_\_.
- I understand that the information in my workers' compensation records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.  
 My initials specifically authorize disclosure of such records  
 My initials do not authorize disclosure of such records
- The records may be disclosed to and used by the following individual or organization:  
\_\_\_\_\_  
Address: \_\_\_\_\_  
For the purpose of: \_\_\_\_\_
- I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present any written revocation to the Division of Workers' Compensation. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_ If I fail to specify an expiration date, event or condition, this authorization will expire in ONE YEAR from the date of execution.
- I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I understand I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of Claimant or Legal Representative (if claimant is deceased, a minor, or incapacitated) \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Claimant or Legal Representative (if claimant is deceased, a minor, or incapacitated) \_\_\_\_\_ Claimant's Date of Birth \_\_\_\_\_

Claimant Address \_\_\_\_\_

If signed by Legal Representative, relationship to Claimant \_\_\_\_\_ Date \_\_\_\_\_

*Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711*



# Video Surveillance



# Social Security Files

**Social Security Benefits Application Form**

By signing and submitting Social Security Benefits, I certify that this application is complete, true and accurate and contains no willful falsifications or misrepresentations. I understand that falsifications, representations, or omissions may disqualify me from consideration for this position. I hereby authorize responsible person to contact current and previous employers for verification, conduct a background investigation, and check my driving record.

Full legal name		
Home Street	Last Name	First
	City	State
E-mail Address:		
Education:		
Best school grade		
Do you have a high school diploma?		
Number of years of post-secondary education		