STATE OF COLORADO
DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

AUTHORIZATION FOR RELEASE OF INFORMATION TO THIRD PARTIES

Claimant Name _____

Claimant Social Security Number _____

Requestor (Third Party) Name: _____

Employer Business Name: _____

The above referenced claimant authorizes limited access to above-mentioned requestor to all workers' compensation files on record as stated below. This authorization shall remain in effect for ninety days from the date of claimant's signature, unless claimant notifies the Division of Workers' Compensation in writing before such time, that claimant is revoking said authorization.

Information provided shall be limited to:

- Workers' Compensation Number
- Date of Injury
- Part of Body
- Employer

_____ _____
Claimant's Signature Date Signed (to be completed by claimant)

Authorization must be signed and dated by the claimant.

Notarization is required

STATE OF)
) ss.
COUNTY OF

When using an embossed seal, please shade before faxing.

Subscribed and sworn to before me this

_____ day of _____ , 20 ____

by _____
(Print name of claimant)

_____
Signature of Notary Public

My commission expires: _____

12/08