

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 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 COLORADO)

) ss.

When using an embossed seal, please shade before faxing.

COUNTY OF DENVER)

Subscribed and sworn to before me this

\_\_\_\_\_ day of \_\_\_\_\_

, 20 \_\_\_\_\_

by \_\_\_\_\_

(Print name of claimant)

\_\_\_\_\_  
Signature of Notary Public

My commission expires: \_\_\_\_\_