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.
COUNTY OF DENVER)

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: ______________________________

3/01