COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers’ Compensation 633 17th Street, Suite 400

Denver, CO 80202-3660

Phone: (303) 318-8700 | Toll Free: (888) 390-7936

Fax: (303) 318-8710

**AUTHORIZATION FOR RELEASE OF INFORMATION**

#  Clear Form

Social Security Number: Claimant Name:

Requestor Name:

The claimant named in the above captioned matter hereby authorizes the above mentioned requestor to have access to this workers’ compensation file. 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. Access to information is as follows (check applicable section or sections):

Complete access

All information except for medical or vocational rehabilitation reports

Other

Claimant’s Signature (in presence of notary) Date Signed (to be completed by claimant)

Authorization must be signed and dated by the claimant.

Notarization is required. **When using an embossed seal, please shade before faxing**

STATE OF COUNTY OF

Subscribed and sworn to before me this

 day of , 20 **.**

by

(Print name of claimant)

Signature of Notary Public

My commission expires:

# Altered forms will not be accepted.

WC 189 Rev. 06/18

Place notary seal here