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) 396-7936
Fax: (303) 318-8710

Clear Form

AUTHORIZATION FOR RELEASE OF INFORMATION

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 _____ Place notary seal here
(Print name of claimant)

_____
Signature of Notary Public

My commission expires: _____

Altered forms will not be accepted.