

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation

633 17<sup>th</sup> Street, Suite 400

Denver, CO 80202-3660

Phone: (303) 318-8700 | Toll Free: (888) 396-7936

Fax: (303) 318-8710

**AUTHORIZATION FOR RELEASE OF LIMITED INFORMATION TO THIRD PARTIES**

Claimant Social Security Number: \_\_\_\_\_

Claimant Name: \_\_\_\_\_

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 (in presence of notary)

\_\_\_\_\_  
Date Signed (to be completed by claimant)

**Authorization must be signed and dated by the claimant.**

**Notarization is required.**

STATE OF \_\_\_\_\_

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)

Place notary seal here

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

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

**Altered forms will not be accepted.**