

# Workersâ€™™ Compensation Information Release Authorization

Claimant Name

Date of Birth

Workersâ€™™ Compensation Claim Number

Employer Name

## Recipient of Information

Name/Organization

Address

## Information to be Released

## Purpose of Release

## Authorization

I hereby authorize the release of the above-mentioned workersâ€™™ compensation information as specified on this form. I understand this authorization can be revoked in writing at any time, except to the extent that action has already been taken in reliance thereon.

Claimant Signature

Date

