

STATE OF COLORADO
DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS COMPENSATION

AUTHORIZATION FOR RELEASE OF INFORMATION TO THIRD PARTIES

CLAIMANT NAME: _____

CLAIMANT SSN:
(Applicant social security number) _____

REQUESTOR (THIRD PARTY) NAME: **ABSO** _____

EMPLOYER NAME: **HAXTUN HOSPITAL DISTRICT** _____

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 Signature

Date Claimant Signed (to be completed by claimant)

Authorization must be signed and dated by the claimant.

Notarization is required

STATE OF COLORADO)ss.

When using a embossed seal, please shade before faxing.

County of _____

Subscribed and sworn to before me this

_____ day of _____, 20_____

by _____
(Print name of claimant)

Signature of Notary Public

My commission expires: _____

3/01