Clear Entire Form

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

AUTHORIZATION FOR RELEASE OF LIMITED INFORMATION TO THIRD PARTIES

Claimant Social Security Number: _____

Claimant Name: _____

Requestor (Third Party) Name: Verified Credentials, Inc.

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 _____

When using an embossed seal, please shade before faxing.

COUNTY OF _____

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.