

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

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

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**RE:**

**CLAIMANT NAME:** \_\_\_\_\_  
(Applicant)

**CLAIMANT SSN:** \_\_\_\_\_  
(Applicant social security number)

**REQUESTOR NAME:** **GOLDEN GATE FIRE PROTECTION DISTRICT and  
ABSOLUTE a consumer reporting (background screening) agency**  
(Employer name AND Employer representative)

The above referenced claimant authorizes limited access 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 authorizations.

Information provided shall be limited to:

- Workers' Compensation Number
- Date of Injury
- Part of Body
- Employer

\_\_\_\_\_  
Claimant  
(Applicant's Signature)

\_\_\_\_\_  
Date Claimant Signed

Must be signed and dated by the claimant/applicant.

Notarization is required

STATE OF COLORADO )ss.  
County of \_\_\_\_\_  
Subscribed and sworn to before me this

When using an embossed seal, please shade before faxing

\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

by \_\_\_\_\_  
(Print name of claimant)

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

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