

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

AUTHORIZATION FOR RELEASE OF INFORMATION TO THIRD PARTIES

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

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

Requestor (Third Party) Name: ABSOLUTE BACKGROUND SEARCH, 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

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

Authorization must be signed and dated by the claimant.

**Notarization is required**

STATE OF \_\_\_\_\_ )  
 ) ss.  
 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)

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

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