

**AUTHORIZATION TO RELEASE
INDUSTRIAL ACCIDENT DIVISION RECORDS**

Please Print or Type

I hereby authorize and request that you release all records pertaining to my industrial injury(s) or illness(s) in your possession.

I authorize the Industrial Accidents Division to release this information to the requesting party, for the purposes of verifying, evaluating, and managing my industrial claim.

By signing this form the claimant is put on notice that his/her records, including medical records, are being made available to the requesting party. This form complies with the state Government Records Access & Management Act (GRAMA).

Records Requested: Date of Injury Listed Only Records for All Injuries (give specific time frame)

PHOTOCOPIES OF THIS AUTHORIZATION ARE AS VALID AS THE ORIGINAL.

Subscribed and sworn to before me this
_____ day of _____ 20_____

Signature of Claimant

Claimant's Name (Printed)

NOTARY PUBLIC

Street Address

Residing at: _____

City/State/Zip

Telephone Number

My Commission Expires: _____

Date of Birth

Social Security Number

This Notarization is valid for 90 days from the signature date.

Date of Injury/Occupational Disease

THIS IS NOT A RELEASE OF CLAIM FOR DAMAGES

Requester's Name (print) _____

Signature _____

Mail Records To _____ Date _____

Street Address _____

City/ State/ Zip _____

Telephone Number _____



Official Form 205 Revised 11/13

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