

Authorization to Release Information

Use this form if you want BWC to share the information we have about you with another person such as:

- · A family member, friend or other relative;
- Someone who helps take care of you;
- Someone who helps you fill out BWC forms.

This authorization is only valid for one year from date of signature.

| Name | | | Date of birth | | Claim number | | |
|---|---|------|-----------------------|--|------------------|---------------------|--|
| Address | | City | | | State | Nine-digit ZIP code | |
| | | | | | | | |
| I authorize BWC to release info below. | ☐ I authorize BWC to release information to the person named below. | | | | | | |
| Name/relationship | Name/relationship | | | | | | |
| Address | Address | | | | | | |
| City, State, ZIP code | | | City, State, ZIP code | | | | |
| Phone number | Fax number | | Phone number | | Fax | Fax number | |
| | • | | | | l . | | |
| Specific information authorized | | | | | | | |
| ☐ Claims status | ☐ Medical documentation | | | | ☐ Wages/payments | | |
| Other | □ Other | | | | | | |
| | | | | | | | |
| Injured worker (or guardian or personal representative) signature | | | | | | Date | |
| If signed by the injured worker's guardian or personal representative, provide here a description of the guardian | | | | | | | |
| or personal representative's authority to sign on behalf of the injured worker | | | | | | | |