

Authorization to Release Information

1. Employee Information.

I, the undersigned, provide the following information to allow the Iowa Division of Workers' Compensation (DWC) to identify me and verify that I signed this Authorization:

Full Name: _____

Social Security Number: _____

Date of Birth: _____

Telephone Number: _____

Address: _____

2. Records to Be Released.

I authorize the DWC to release the following confidential information filed within the past _____ years:

- All confidential records of any nature
- Information from all First Reports of Injury (FROI)
- Information from all Subsequent Reports of Injury (SROI)
- All evidence received in contested case hearings
- All transcripts from contested case hearings
- Other (describe the records that you want released):

3. Recipient(s) of Records.

I authorize the DWC to release the confidential information identified in Section 2 to:

Name(s): _____

4. Signature.

I understand that I have the right under Iowa Code section 86.45 to keep confidential certain information filed with the DWC.

By signing this Authorization, I authorize the DWC to release the confidential information identified in Section 2 to the recipient(s) identified in Section 3.

X

 Signature

 Date