IOWA WORKFORCE DEVELOPMENT

IOWA DIVISION OF
WORKERS' COMPENSATION
www.IowaWorkComp.gov

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