

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

AUTHORIZATION AND RELEASE OF INFORMATION WAIVER FOR THIRD PARTIES

CLAIMANT \_\_\_\_\_  
NAME (Employee Name)

CLAIMANT \_\_\_\_\_  
SSN (Employee Social Security Number)

CLAIMANT \_\_\_\_\_  
DATE OF BIRTH (Employee Date of Birth)

\_\_\_\_\_  
(Employee Address) (City) (State) (Zip)

REQUESTER University of Denver  
NAME (Employer's Company Name)

EMPLOYER Background Information Services, Inc  
REPRESENTATIVE (Employer's Representative Name)

THE ABOVE REFERENCED CLAIMANT AUTHORIZES BACKGROUND INFORMATION SERVICES, INC. LIMITED ACCESS 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

\_\_\_\_\_  
CLAIMANT DATE  
(Employee Signature)

NOTARIZATION IS REQUIRED  
Subscribed and affirmed, or sworn before me in the  
County of \_\_\_\_\_ )

*When using an embossed seal, please shade before faxing*

State of \_\_\_\_\_ )

this \_\_\_\_\_ day of \_\_\_\_\_, Year \_\_\_\_\_

By \_\_\_\_\_  
(Signature of Notary Public)

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