Return completed form to:
Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

Authorization to Release Information

Worker Information:

Worker Name:	Claim Number:
Social Security Number (for ID only):	Date of Birth:

Provider:

Provider Name:

I am authorizing you to give Labor and Industries or its representative any information you may have regarding my condition(s) while under your treatment.

In addition to your observations, please include:

- Records of medical history.
- Examinations.
- Consultations.
- X-Ray reports.
- Laboratory studies.
- Operative and pathology reports.
- Physicians' and nurses' notes.
- Hospital records.
- Diagnoses.
- Prescription or treatment information relating to any disease, injury or other physical condition.

Please release all records of treatment for:

_____

_____

_____

_____

_____

_____

_____

_____

Data to be release includes:

☐ Alcohol abuse ☐ Drug abuse ☐ HIV/AIDS ☐ Psychiatric care

And/or other information protected by federal law.

I understand I am releasing these records so that Labor and Industries can administer and process my claim. I understand these records will be treated confidentially in accordance with state law (RCW 51.28.070).

This authorization can be withdrawn by me at any time.

_____ _____

Worker Signature Date

RESET