

**AUTHORIZATION FORM FOR FILE REVIEW OR RELEASE OF COPIES OF  
WORKERS' COMPENSATION CLAIMS FILE.**

To: STATE OF MINNESOTA  
Worker' Compensation Administrative Operations  
Records Section  
Attn: Copy — File

I hereby authorize all Agents and Assigns, to review and/or receive copies of any or all parts of the Minnesota Worker' Compensation claims file (s), for the date (s) or injury, any and all first reports. This authorization is valid for six months from the date signed.

Employee Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Insurer Name (if known): \_\_\_\_\_

Date (s) of Injury: \_\_\_\_\_

Information concerning disability may not be used to make a job decision unless state or federal law requires use of this information. Any use or distribution of this information beyond that authorized by the subject of this data unless authorized by state or federal law is prohibited. Questions concerning use of disability information may be directed to the Minnesota Department of Human Rights at (612) 296-5663, or toll free in greater Minnesota at 1-800-652-9747.

---

Signature

Company Name (if applicable)

---

Date

\*This request is a condition on a job offer.