RESET

Claims Section
Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

AUTHORIZATION TO RELEASE CLAIM INFORMATION

(to be completed by the worker

Claim No.

You or your delegate can also view your claim file documents online at the department's Claim and Account Center. For more information go to:www.Claiminfo.LNI.wa.gov.

This form must be completed in full

I, _____ , designate the following individual as my authorized representative.

_____
Name of authorized representative (please print))

Phone number
( )

Address

City State ZIP +4

Please check the proper box(s).

☐ I am authorizing the release of my claim file to the authorized representative named above for review.

☐ I am authorizing the mailing of my claim file, checks & correspondence from this date forward to the authorized representative's address listed above.

☐ I am authorizing, but limit the release of information (to the authorized representative) from my claim file to the following: (*for example, "all non-medical records", "the panel exam of Feb 4, 1977", etc.): please list limitations below.*

This authorization will remain in effect UNTIL REVOKED IN WRITING by the claimant.

Date	Phone number **( )**	Worker's address	
City	State ZIP		Worker's Signature