



RELEASE OF INFORMATION
 CLAIMS DIVISION
 SFN 50381 (09/2018)

1600 E Century Ave, Ste 1
 PO Box 5585
 Bismarck ND 58506-5585
Telephone 800-777-5033
 Toll Free Fax 888-786-8695
 TTY (hearing impaired) 800-366-6888
 Fraud and Safety Hotline 800-243-3331
 www.workforcesafety.com

SECTION 1 – Injured worker’s information

Claim number	Injured worker’s (First name)	(Last name)
Other name (Example: maiden, previous, or nickname)		
Address		
City	State	ZIP code
Social Security number*		Date of birth

SECTION 2 – Authorization

I authorize Workforce Safety & Insurance to release the following records:

- All information and records on file
- Correspondence only
- Medical records only
- Rehabilitation reports only
- Compensation and medical payment information only
- School records (including grades and attendance)
- Other (specify)

Release these records to:

SECTION 3 – Signature

A copy of this authorization is considered as valid as the original and is in effect until revoked by me in writing.

Injured worker’s signature	Date
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* In compliance with the Federal Privacy Act of 1974, disclosure of the social security number on this form is mandatory pursuant to N.D.C.C. 65-05-02. The social security number is used for identification and verification purposes. Failure to provide this information may result in a delay in processing your request.

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