MINNESOTA
DIVISION OF WORKERS= COMPENSATION
RECORDS DEPARTMENT

AUTHORIZATION FOR RELEASE OF INFORMATION TO THIRD PARTIES

Claimant Name: _____
(Applicant)

Claimant SSN: _____
(Applicant Social Security Number)

Claimant Date of Birth: _____

Prospective Employer: _____

The above referenced claimant authorizes American Screening, LLC. access to all workers= compensation files. Claimant further acknowledges that above requestor/employer has made a conditional job offer prior to workers compensation records search. 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. All information requested is to be used only in compliance with the Americans With Disabilities Act.

_____ _____
Claimant Date Claimant Signed
(Applicant=s Signature)