

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

To: STATE OF MINNESOTA
Workers' Compensation Information Processing Unit
Copy/File Review Area

I hereby authorize Premier Employment Screening Services to review and/or receive copies of any or all

parts of the Minnesota Workers' compensation claim file(s), for the date(s) of injury as indicated

below. This authorization is valid for six months from the date signed. Medical and Workers' Compensation

information will only be requested in compliance with the Federal Americans with Disabilities Act (ADA).

Employee Name: _____

Social Security Number: _____

Employer Name: _____

Insurer Name (if known): _____

Date(s) of ANY and ALL injuries: _____

Information concerning disability may 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