

**AUTHORIZATION FOR FILE  
REVIEW OR RELEASE OF  
COPIES OF WORKERS'  
COMPENSATION CLAIM FILE**



DO NOT USE THIS SPACE

TO: Department of Labor and Industry  
Workers' Compensation File Review  
PO Box 64226  
St. Paul, MN 55164-0226  
(651) 284-5200  
Fax: (651) 284-5731

I hereby authorize \_\_\_\_\_ to review and/or receive copies of any or all parts of the Minnesota workers' compensation claim file(s) maintained by the Department of Labor and Industry (DLI) for the employee and date(s) of injury indicated below.

|          |                    |                   |
|----------|--------------------|-------------------|
| EMPLOYEE | WID or SSN         | DATE(S) OF INJURY |
| EMPLOYER | INSURER (if known) |                   |

- Following receipt of this properly completed authorization, DLI may release information from the workers' compensation claim file about the above-named employee, employer and insurer, including the employee's worker identification number (WID) and social security number, that would not otherwise be accessible to the public. The WID is a unique number assigned by DLI to an injured worker and may be used instead of the employee's SSN.
- Once this information is released, DLI does not control how it is used or further distributed by the recipient.
- A copy of this authorization may be used in the same manner and with the same effect as the original document.
- This authorization is valid for six months from the date signed, or until this consent is withdrawn by notifying DLI in writing at the above address or facsimile number.

|  |   |
|--|---|
| Print name of person authorizing release | I am authorized to sign this form because I am the:<br><br>employee<br><br>parent/guardian of a minor or incapacitated employee (if not the parent, attach a court order documenting guardianship)<br><br>employer (state title at employer): _____<br><br>insurer (state title at insurer): _____<br><br>dependent of deceased employee (state relationship): _____<br><br>representative of employee's estate (attach court order)<br><br>representative of the DLI Special Compensation Fund |
| Signature of person authorizing release  |   |
| Date signed                              |   |

**NOTICE:** Information concerning disability may not be used to make a job decision unless state or federal law permits use of this information. Unless authorized by state or federal law, any use or distribution of this information beyond that authorized by the subject of this data is prohibited. Questions concerning use of disability information may be directed to the Minnesota Department of Human Rights at (651) 296-5663 or 1-800-657-3704.

INSTRUCTIONS FOR AUTHORIZATION TO REVIEW OR RELEASE  
COPIES OF MINNESOTA WORKERS' COMPENSATION CLAIM FILE

Minnesota Statutes, § 176.231, subdivision 9 requires that information in a workers' compensation claim file maintained by the Department of Labor and Industry (department) may not be released without the authorization of the employee, employer, insurer, or dependent of the deceased employee.

Minnesota Rules, part 5220.2880, subpart 1, requires an authorization to:

- be in writing;
- be signed and dated within the last six months by the employee or legal guardian, employer, insurer, special compensation fund, or dependent of a deceased employee for the specified date of injury; and
- specify who is authorized to review the file.

The department may ask for additional information to verify the identity of the person authorizing the release or the relationship of the person to a party to the claim. Claim file information may not be released over the telephone without this authorization in the department's file. The department will only copy or permit review of claim file information for the dates of injury indicated on the authorization. **If the authorization is for all dates of injury for an employee, indicate "any and all" dates of injury.** An employer or insurer must obtain an authorization from the employee to review a workers' compensation file for which it is not a party.

This authorization must be signed and dated by an authorized person and filed with the Department of Labor and Industry by mail or in person.

| <b>In Person:</b>                 | <b>Mailing Address:</b>           |
|-----------------------------------|-----------------------------------|
| Department of Labor and Industry  | Department of Labor and Industry  |
| Workers' Compensation File Review | Workers' Compensation File Review |
| 443 Lafayette Road N.             | PO Box 64226                      |
| St. Paul, MN 55155-4301           | St. Paul, MN 55164-0226           |

If you have questions, the worker's compensation file review office can be reached at 651-284-5200; toll-free: 800-342-5354; and TTY: 651-297-4198.