

From:
To: OWCP/DOL

Subj: AUTHORIZATION TO RELEASE INFORMATION

1. I, _____, SSN (LAST 4) _____, grant authorization to the below listed Unit/Medical Claim Officer(s) to discuss any and all matters relating to my Worker's Compensation Claim with DOL, as required.

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2. If there are any questions, I can be reached by phone at _____.

Signature

Date

PRINT NAME