Ohio | Bureau of Workers' Compensation

Authorization to Release Information

Use this form if you want BWC to share the information we have about you with another person such as:
- A family member, friend or other relative;
- Someone who helps take care of you;
- Someone who helps you fill out BWC forms.

This authorization is only valid for one year from date of signature.

Name		Date of birth	Claim number
Address	City	State	Nine-digit ZIP code

☐ I authorize BWC to release information to the person named below.			☐ I authorize BWC to release information to the person named below.	
Name/relationship		And/or	Name/relationship	
Address			Address	
City, State, ZIP code			City, State, ZIP code	
Phone number	Fax number		Phone number	Fax number

Specific information authorized

☐ Claims status ☐ Medical documentation ☐ Wages/payments

☐ Other _____ ☐ All

Injured worker (or guardian or personal representative) signature	Date

If signed by the injured worker's guardian or personal representative, provide here a description of the guardian or personal representative's authority to sign on behalf of the injured worker. _____

_____ .