

COUNTY OF SACRAMENTO
WORKERS' COMPENSATION OFFICE
AUTHORIZATION TO RELEASE RECORDS

PHONE (916)876-5251

FAX (916)876-5157

I, _____, hereby authorize any person in possession and/or in control of all records, including but not limited to medical, mental health, drug and/or alcohol treatment, employment, personnel, group insurance, and retirement records, to release those records to an agent, designee or representative of the County of Sacramento Workers' Compensation Office for the purpose of photocopying, review, investigation, inspection or evaluation of any claim filed against the County of Sacramento for Workers' Compensation benefits or any other benefits or damages.

This authorization shall become effective immediately and shall remain in effect for three (3) years unless otherwise revoked in writing. Photocopies of this authorization may be used with the same force and effect as the original. I understand that I am entitled to a copy of this authorization.

Date _____ Employee Signature _____

Date of Birth _____

SSN _____

Please forward the completed form to the Workers' Compensation Office
PO Box 276130, Sacramento, CA 95827
Mail code: 58-600