AUTHORIZATION TO RELEASE INFORMATION

| I,, authorize the Office of the Ombuds, pursuant to RCW 51.14.340370, RCW 51.14.120(1) and WAC 296-15-420(7), to contact all of my medical providers, former or present employers, and vocational providers for the purposes of identifying, investigating, and facilitating resolution of industrial insurance issues. This may include information of a confidential or privileged nature, to include but is not limited to my workers' compensation claim file, and/or contacting anyone else who might be familiar with these issues. |
|---|
| I knowingly and voluntarily release the state of Washington, the Washington State Department of Labor and Industries, its individual employees and the Office of the Ombuds from any and all known and unknown claims for damages or other relief arising out of the Office of the Ombud's request for and receipt of information. |
| I understand that pursuant to RCW 51.14.360(2), no discriminatory, disciplinary, or retaliatory action may be taken against any employee of a self-insured employer for any communication made, or information given or disclosed, to assist the Office of the Ombuds in carrying out its duties and responsibilities, unless the same was done maliciously. |
| A photocopy of this signed Authorization is as valid as the original and shall be provided to anyone from whom information is requested regarding industrial insurance issues. |
| This release will expire upon resolution of the issues involved, or at my express written request. |
| |
| (Print Name) FIRST MIDDLE LAST |
| (List any AKA's) |
| (Signature) (Date) |
| Claim number: |