STATE OF MONTANA
WORKERS COMPENSATION RECORDS SEARCH RELEASE

AUTHORIZATION FOR RELEASE OF INFORMATION TO THIRD PARTIES

Claimant Name: _____

Claimant Social Security Number: _____

Requestor (Third Party) Name: **TruDiligence, LLC.**

Employer Name: _____

The above referenced claimant authorizes limited access to above mentioned requestor to all Montana workers compensation claims history on record as stated below. This authorization shall remain in effect for ninety days from the date of claimants signature, unless claimant notifies the Division of Workers Compensation in writing before such time, that claimant is revoking said authorization. Claimant certifies that in accordance with the Americans with Disabilities Act, a conditional job offer has been made prior to requesting access to Workers Compensation files.

Information provided may be limited to:

- Workers Compensation Number
- Date of Injury
- Part of Body
- Employer

_____ _____
Claimant Signature Date Signed (to be completed by claimant)

Authorization must be notarized, signed and dated by the claimant.

Notarization is required

STATE OF _____)
) ss.
COUNTY OF _____)

When using an embossed seal, please shade before faxing.

Subscribed and sworn to before me this

_____ day of _____, 20_____

by _____
(Print name of claimant)

_____
Signature of Notary Public

My commission expires:_____

Please send results via fax to: TruDIligence Fax: 303 692 8511