

STATE OF NEW JERSEY
DEPARTMENT OF LABOR
DIVISION OF WORKERS COMPENSATION

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 workers compensation files 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 signed and dated by the claimant.

Send return to: TruDiligence
3190 S Wadsworth Blvd
Suite 260
Lakewood, CO 80227

Office: 303 692 8445
Fax: 303 692 8511