

STATE OF SOUTH DAKOTA  
DIVISION OF WORKERS' COMPENSATION  
RECORDS DEPARTMENT

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**AUTHORIZATION FOR RELEASE OF INFORMATION**

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Claimant Name:  
(Applicant)

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Claimant SSN:  
(Applicant Social Security Number)

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Requestor Name:  
(Employer Name)

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The above referenced claimant authorizes TruDiligence access to all South Dakota workers' compensation files. Claimant further acknowledges that above requestor/employer has made a conditional job offer prior to workers compensation records search. This authorization shall remain in effect for ninety days from the date of claimant's signature, unless claimant notifies the Division of Workers' Compensation in writing before such time, that claimant is revoking said authorization.

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Claimant  
(Applicant's Signature)

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Date Signed

Must be signed and dated by the claimant/applicant.