



**STATE OF ALASKA
DIVISION OF WORKERS' COMPENSATION
REQUEST FOR RELEASE OF INFORMATION**

Pursuant to Alaska Statute 23.30.107, medical or rehabilitation records maintained by the Alaska Workers' Compensation Division, or held by the Alaska Workers' Compensation Board, including employee personal information, are not public records subject to public inspection under AS 40.25. To obtain records from the Division or the Board, you are required to

- 1) Provide the information requested below. An incomplete form will delay processing your request.
- 2) Provide photographic identification.
 - a. For an in-person request, show your photo ID to Division staff.
 - b. For mail-in, fax, or email requests, attach a copy of your ID to this form.
- 3) Pay the applicable reproduction fee. (See reverse side for fee schedule)

A request for information by a person other than the employee may require the employee's written consent. See below.

Requestor's Printed Name:

Firm Name (if applicable):

Requestor's Mailing Address:

Requestor's Phone Number:

Fax Number:

Email:

Requestor's Status: Employee Employer Insurer Claims Administrator
 Legal Representative Rehabilitation Specialist assigned under AS 23.30.041
 Other (describe below)

Employee's Name: (First, Last, Middle Initial)

Employee's Employer at the time of injury:

Employee's Date of Injury:

Information Requested: Copy of Employee Case File
 Other (describe below or attach documentation)

Requestor's Signature:

Date:

Employee's Declaration

(Required if requestor is not the employee, the reemployment benefits administrator, the Workers' Compensation Appeals Commission, a physician providing medical services under AS 23.30.095(k) or 23.30.110(g), a party to a claim filed by the employee, or a government agency)

I hereby authorize release of the aforementioned information. This consent is limited to the work related injuries referenced above on an ongoing basis. I understand that an additional consent to release information will not be necessary unless or until I revoke this authorization in writing.

Signed: _____ Date: _____

Mail Completed Form To the Division of Workers' Compensation at one of these offices:

ANCHORAGE
 P.O. Box 107019
 Anchorage, AK 99510-7019
 (907) 269-4980 (phone)
 (907) 269-4975 (fax)

FAIRBANKS
 675 Seventh Ave., Station K
 Fairbanks, AK 99701-4593
 (907) 451-2889 (phone)
 (907) 451-2928 (fax)

JUNEAU
 P.O. Box 115512
 Juneau, AK 99811-5512
 (907) 465-2790 (phone)
 (907) 465-2797 (fax)

THIS SIDE FOR DIVISION USE ONLY

After information has been provided in response to receipt of a Request For Release of Information, a copy of this form must be placed in the employee's case file. All requests for database information must be forwarded to the Juneau office.

Date Request Received:

Injured Worker's Name (First, Last, Middle Initial):

AWCB Case Number(s):

Requestor's Photo ID Type: Driver's License Military ID Passport Other (describe below)

Identification Number:

Signature of staff who checked Photo ID:

File Copied By:

Mailed on _____ by _____ Picked up on _____ by _____
(date) (staff name) (date) (name)

Bill Prepared By:

Bill Mailed on _____ by _____
(date) (staff name)

FEE SCHEDULE

(Check or Money Order Only)

An injured worker may obtain the first copy (if under 100 pages) or first 100 pages of their case file at no charge. Subsequent requests will be charged the standard copy rates listed below.

Paper Copies: \$.35 per page

Microfilm Copies: \$.75 per page

Microfiche Copies: \$50.00 per fiche

Certification of Copies: \$5.00 per certification

Hearing/Pre-Hearing Recording Copies: \$10.00 per recording

Data Query: \$80.00/hr, \$20.00 (¼ hr) minimum