



Matthew H. Mead
Governor

State of Wyoming
Department of Workforce Services
DIVISION OF WORKERS' COMPENSATION
1510 East Pershing Boulevard, South Wing
Cheyenne, Wyoming 82002
<http://www.wyomingworkforce.org>



John Cox
Director
John Ysebaert
Interim Deputy Director

RELEASE OF INFORMATION

Please sign and return this form only if you would like to designate any other person (i.e. spouse, mother, father, brother, family member, etc.) to inquire about the status of your claim, or to give information about your claim to the Wyoming Workers' Compensation Division. Thank you.

Claim Number _____

Last 4 digits of SSN _____

I, _____ give my permission for my _____,
(name of injured worker) (state relationship)

_____ to give and receive
(name) (phone number)

information regarding my Workers' Compensation claim. I give permission for the Division to speak to the above person on issues concerning my claim.

(signature of injured worker)

(date)

