

# WCRB—INFORMATION RELEASE AUTHORIZATION FORM

Date: \_\_\_\_\_

The undersigned insured does hereby authorize the release by the Wisconsin Compensation Rating Bureau (WCRB) of designated information to:

\_\_\_\_\_  
(Name and address) ("Designee") with respect to the following policy of worker's compensation insurance:

Policy No: \_\_\_\_\_

Policy Period: \_\_\_\_\_

Insurer: \_\_\_\_\_

Named Insured (as shown on the policy): \_\_\_\_\_

**(The Named Insured and the company submitting this authorization form must be the same. An original of this release form must be submitted to WCRB. Photocopies, faxes, or e-mails will not be accepted.)**

Information Requested:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The Insured does specifically acknowledge that WCRB has the right but not the obligation to release information pursuant to this letter of authorization and that the WCRB may suspend the release of information at any time and for any reason.

In exchange for the receipt of this information, which the undersigned acknowledges constitutes good and valuable consideration for the following covenants, the undersigned does hereby represent and warrant to WCRB as follows:

(a) Authorization. The undersigned is a duly authorized officer or owner of the Insured with full legal authority to authorize the release of the above-described information and to enter into on behalf of the Insured the following covenants.

(b) Period of Authorization. This authorization applies only to the policy listed and shall expire 180 days from the date of this release form.

(c) Waiver of Rights. The undersigned on behalf of the Insured does hereby unconditionally waive any and all legal protections or prohibitions, whether arising under state or federal statutes, regulations, court decisions or doctrines of common law, including specifically but not exclusively all rights of privacy related to payroll, claim or medical information, arising from or related to any and all of the information or documents released to Designee, including information inadvertently released to Designee (Released

Information). This waiver is made on behalf of the Insured and any past or present employees of the Insured whose information may be contained in the Released Information.

(d) Indemnification. The undersigned on behalf of the Insured does hereby agree to save and hold the WCRB harmless from and against any and all manners of action, causes of action, suits, proceedings, damages, judgments, levies, executions, claims and demands of whatsoever kind or description (collectively "Claims"), including all attorney fees incurred by WCRB, as a result of providing the Released Information to Designee or the use or distribution of the Released Information by Designee. This indemnification shall include specifically but not exclusively any Claims by any past or present employee of the insured.

(e) Knowing Release. It is expressly represented and agreed that Insured before executing these covenants fully informed itself of the terms, contents, conditions and effects thereof; elected or declined the benefit of consulting attorneys or its choosing; and executed this letter voluntarily, for reasons of its own, after having had full opportunity to review each and every obligation as set forth herein.

(f) Disputes. Any and all matters related to the enforceability of these covenants shall be venued exclusively in Waukesha County Circuit Court and shall be governed by Wisconsin law. The Insured does waive all objections to jurisdiction and venue and does consent to the jurisdiction of this court.

Dated: \_\_\_\_\_  
By \_\_\_\_\_  
Its \_\_\_\_\_  
Insured

STATE OF \_\_\_\_\_ )  
) ss.  
COUNTY OF \_\_\_\_\_ )

\_\_\_\_\_, being first duly sworn on oath, deposes and says that he/she is the \_\_\_\_\_ of \_\_\_\_\_, that he/she has read the foregoing and is fully authorized to enter into the foregoing covenants and does so as his/her voluntary act and deed.

\_\_\_\_\_  
Subscribed and sworn to before me  
This \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Notary Public

SUBMIT FORM TO: WISCONSIN COMPENSATION RATING BUREAU  
P.O. Box 3080  
Milwaukee, WI 53201-3080