South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5675

Authorization of Release of Claims Data

TO BE COMPLETED BY THE EMPLOYEE/CANDIDATE

I, _____, understand that the records of the Workers' Compensation Commission in so far as they refer to my accidents, injuries, and/or settlements, are not open to the public, but only to me, the injured worker, my employer, and their representatives. I am voluntarily waiving my right to have my records in the possession of the Workers' Compensation Commission kept private.

I hereby authorize the South Carolina Workers' Compensation Commission to release my records to:

Business Name: _____

Mailing Address: _____

City: _____

State, Zip _____

I hereby release, discharge, exonerate, and agree to indemnify the South Carolina Workers' Compensation Commission, its agents, representatives, and any persons so furnishing information, from any and all liability of every kind and nature arising out of the furnishing or inspection of such documents, records, and other information, specifically including any attorneys' fees and costs incurred by the south Carolina Workers' Compensation Commission as a result of the furnishing of the requested information.

I understand that any suspected misuse of my personal information is for the purposes of unlawful discrimination or unfair treatment in employment should be reported to the South Carolina Human Affairs Commission, 1026 Sumter Street, Suite 101, Columbia, S.C. 29201.

_____ _____

Signature Date

_____

Print Name

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TO BE COMPLETED BY THE REQUESTER

I, the undersigned, being first duly sworn, on oath depose that

1) I have obtained the attached informed, written consent from the individual about whom I am requesting information for the South Carolina Workers' Compensation Commission to release the requested information;
2) I swear or affirm that the requested information will not be used for any unlawful purpose;
3) Specifically, I swear or affirm, under the penalty of perjury, that the requested information will not be used by me or by any entity to which I provide the requested information:
    a. to fail or refuse to hire, or assist another entity in failing or refusing to hire, an individual because of disability;
    b. as qualification standards or other selection criteria that tend to screen out an individual with disabilities;
    c. to make inquiries of a job applicant as to whether applicant is an individual with a disability;
    d. to discharge or demote any employee for participating in the workers' compensation system;
    e. to refuse to hire an applicant for participating in the workers' compensation system;
    f. to otherwise discriminate against an applicant or employee for participating in the workers' compensation system;
    g. to discriminate against a qualified individual on the basis of disability in regard to job application procedures or the hiring of employees;
    h. to conduct a medical examination, or make inquiries of a job applicant as to whether such applicant is an individual with a disability or as to the nature or severity of such disability, other than inquiries narrowly-tailored to determine whether an applicant is capable of performing specific job-related functions;
    i. to obtain from the South Carolina Workers' Compensation Commission any information that cannot be lawfully obtained from the applicant or employee;
    j. for any other purpose in contravention to the laws of the State of South Carolina, the United States of America, or any other relevant jurisdiction.

I hereby release, discharge, exonerate, and agree to indemnify the South Carolina Workers' Compensation Commission, its agents, representatives, and any persons so furnishing information, from any and all liability of every kind and nature arising out of the furnishing or inspection of such documents, records, and other information, specifically including any attorneys' fees and costs incurred by the South Carolina Workers' Compensation Commission as a result of the furnishing of the requested information.

_____
Business Name

_____
Signature Business Representative

_____
Print Name Business Representative

_____
Date

Subscribed and sworn to or affirmed before me this _____ day of _____, 20___.

_____
Signature of Notary Public

My commission expires _____

Seal or stamp must be affixed to each original.

Questions about the use of this form should be directed to the Claims Department at 803-737-1234, or **claims@wcc.sc.gov**. Mail the completed form, along with a $25.00 fee, to the attention of the Claims Department, P.O. Box 1715, Columbia, SC 29203.