

## **OWCP - AUTHORIZATION TO REPRESENT AND RELEASE INFORMATION**

Full Name: \_\_\_\_\_

OWCP File No.: \_\_\_\_\_

Social Security No.: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

To Whom It May Concern:

I hereby authorize the following named person or persons of the NALC and/or their designees to represent me in regard to the above OWCP case file and any other action pursuant to the FECA in my behalf.

### **1—Local**

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

### **2—Regional**

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

### **3—National**

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

The person or persons named are authorized to inspect and discuss my OWCP case file (and other case files pertaining to me) and to obtain copies of documents as requested.

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

Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

Telephone: \_\_\_\_\_

Original to: US Department of Labor  
Office of Workers' Compensation Programs

Copy to: Each person listed above