CERTIFIED AUTHORIZATION FOR RELEASE OF RECORDS
DEPARTMENT OF ECONOMIC OPPORTUNITY (DEO)

Reemployment Assistance (RA) Benefit Records • P.O. Box 5750 • Tallahassee • FL 32314-5750 • (800) 204-2418

This authorization is for the release of confidential information contained in the records of the Department of Economic Opportunity

A person receiving confidential RA information through use of this form in violation of Chapter 443, Florida Statutes, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. § 443.1715(1), Florida Statutes

THIS AUTHORIZATION IS VALID FOR A PERIOD OF 60 DAYS FROM THE DATE SIGNED

INSTRUCTIONS: For all requests, SECTION II, III or IV of this form must be fully completed, as applicable. If the required SECTIONS are not fully completed, this may cause a delay or denial of access to the requested records. Mail completed request along with a self-addressed, postage paid envelope to: Department of Economic Opportunity, Reemployment Assistance Records, P.O. Box 5750, Tallahassee, Florida 32314-5750.

SECTION I – (Select all that apply)

- ❑ I am the Claimant/Claimant's representative requesting Claimant's information. No fee will be assessed. (Complete SECTION II).
- ❑ I am an Employer/Employer's representative requesting the Employer's information. No fee will be assessed. (Complete SECTION III).
- ❑ I am a party requiring an opposing party's information for a Reemployment Assistance proceeding. No fee will be assessed. (Complete Section II and III).
- ❑ I am a Third Party Requestor (a workers compensation carrier, a third party conferring a benefit or service upon a Claimant or Employer, or a representative of a Claimant or Employer). (Complete SECTION IV, and SECTIONS II and/or III).

The information I am requesting is:

- ❑ Entire File
- ❑ Printout of RA Benefit Payments History
- ❑ Wages Records Information
- ❑ Other (Please specify) ______________________________

SECTION II – Claimant Information - Complete if requesting Claimant information.

Name: ______________________________ Social Security Number (SSN) ______________________

(Collection of your SSN is authorized by law and required for record retrieval. § 443.091, Florida Statutes. Your SSN will not be used for any other purpose.)

Address: ______________________________

Street City State Zip Code

Date of Birth: ____________________ Telephone: ______________________

mm/dd/yyyy

SECTION III – Employer Information - Complete if requesting Employer information.

Employer Name: ______________________________

Contact Name/Title: ______________________________ Telephone Number: ______________________

Address: ______________________________

Street City State Zip Code

SECTION IV – Third Party Requestor

Requestor/Company Name:

____

Contact Name/Title: ______________________________ Telephone Number: ______________________

Address: ______________________________

Street City State Zip Code

NOTE: If you are a Third Party Requestor the certified signatures in Section V, provided on **page 2** of this form, must be completed.

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SECTION V –

Third Party Requestor Acknowledgment and Agreement of Records Requestor from SECTION IV

By signing and submitting this form, the requestor acknowledges and agrees to the following:

1. The Third Party Requestor acknowledges that he/she is a workers compensation carrier, a third party conferring a benefit or service upon a Claimant or Employer, or representative of a Claimant or Employer.
2. The Third Party Requestor, if a worker's compensation carrier, shall use the information provided only for the purposes of determining whether the Claimant identified in SECTION II of this form is eligible for workers' compensation and for the purposes of any mediation, negotiation, arbitration or litigation relating to the Claimant's claim for workers' compensation.
3. The Third Party Requestor shall store the information in a location and manner that is inaccessible to unauthorized persons and made available only to authorized persons with a need for access to the information.
4. The Third Party Requestor shall instruct all personnel having access to the information about the confidentiality requirements set forth in Chapter 443, F.S. and on this form.
5. The Third Party Requestor acknowledges that anyone who unlawfully discloses the confidential wage information is guilty of a second degree misdemeanor. s. 443.1715, F.S.
6. The Third Party Requestor acknowledges that DEO reserves the right to conduct an on-site inspection to assure the requirements of the law and this agreement are being met.
7. The Third Party Requestor agrees to pay any applicable costs associated with providing the data requested. Title 20 Part 603, Code of Federal Regulations.
8. The Third Party Requestor understands that the information requested may contain inaccuracies due to errors made by employers in their quarterly wage reports and the Department of Economic Opportunity shall not be responsible or liable for any errors contained in the information.

As the Third Party Requestor, I HEREBY ACKNOWLEDGE THAT I AM A PARTY ENTITLED TO THE INFORMATION IDENTIFIED IN SECTION I AND THAT THE INFORMATION CONTAINED IN THIS FORM IS ACCURATE AND TRUTHFUL.

____ ____________________

Signature of Third Party Requestor Date

Claimant/Employer Certification pursuant to 20 CFR 603.5(d)(2) - Required only where there is a Third Party Requestor.

By signing this form, the Claimant and/or Employer certifies and acknowledges the following:

1. I am the Claimant and/or Employer identified in SECTION II and/or III and that the information contained in this form is accurate and truthful. I authorize the release of my information to the requestor named in SECTION IV.
2. The release of the records identified herein provides a service or benefit to me.
3. **If this request involves a Workers Compensation Claim:** Section 443.1715(2)(b)1, Florida Statutes, provides: The Employer or the Employer's workers' compensation carrier against whom a claim for benefits under Chapter 440, Florida Statutes, has been made, or a representative of either, may request from the Department of Economic Opportunity records of wages of the Claimant reported by an Employer for the quarter that includes the date of the accident that is subject of such claim and for subsequent quarters. The request must be made with the authorization or consent of the Claimant or any Employer who paid wages to the Claimant subsequent to the date of the accident. The Florida Workers' Compensation Act provides that workers' compensation benefits shall be reduced by the amount of the reemployment assistance (or unemployment compensation) received (Section 440.15(10), F.S.). **To allow determination of the proper amount of workers' compensation, I hereby authorize release of reemployment assistance information relative to my account.**

____ ____________________

Signature of person that is subject to this request. (Claimant/Employer) Date