**AUTHORIZATION TO RELEASE**

**DISTRICT OF COLUMBIA AND FEDERAL TAX INFORMATION**

*(Form must be notarized)*

TO WHOM IT MAY CONCERN:

I, Claimant Name, hereby authorize the Director of the Office of Risk Management and/or his or her designee, bearing the release or copy of this document, within six months of the date it is notarized, to obtain information and/or documents related to either my District of Columbia or United States federal tax records for the 2014 tax year. *See* DC Official Code § 1-623.06b.

This release is executed with full knowledge and understanding that the information is for the official use of the District of Columbia Office of Risk Management to establish compliance with the Public Sector Workers’ Compensation Program of the District of Columbia Government, and with the exception that this information may be used by the Program to enforce compliance through litigation, this information may not be disseminated to third parties without my written permission. I hereby release the custodian of D.C. and/or federal tax records from any and all liability for damages of whatever kind, which may at any time result to me, my heirs, family or associates because of compliance with this authorization and request to release information, or any attempt to comply with it.

I hereby authorize the Office of the Chief Financial Officer, Office of Tax and Revenue, and officials of the Internal Revenue Service access to review and research my taxes for the tax year of 2014, and to release the same information to the Director of the Office of Risk Management and/or his or her designee.

I further authorize the Office of Tax and Revenue and/or the Internal Revenue Service to stipulate whether I filed District of Columbia and/or federal Tax Returns for the tax year of 2014 or any part of the year(s) thereof, to the Director of the Office of Risk Management and/or his or her designee.

I further understand that the information received from the Office of Tax and Revenue and/or Internal Revenue Service pursuant to this release will be placed in a confidential file to be maintained by the District of Columbia Office of Risk Management and is not subject to dissemination to any individual outside of the District of Columbia Office of Risk Management, with the exception of use by the Program to enforce compliance through litigation, as stated above.

FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature)

FULL NAME: CLAIMANTS NAME

(Typed or Printed)

SOCIAL SECURITY NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYING AGENCY/OFFICE AT TIME OF INJURY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed and sworn before me this \_\_\_\_\_\_day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_.

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

 **Notary Public**

My commission expires: \_\_\_\_\_\_\_\_\_