Medical Authorisation Form



WHS-PRO-FORM-006c

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l <u>,</u>	(name),	(date of birth),
Injury Prevention and Management Ac	ng specified treatment providers to discuss was livisor, the medical information relevant solel ssisting with my workplace rehabilitation and	y to this specific injury
Treating Doctor/s (Name)		
Address / Practice		
Medical Specialist (Name)		
Address / Practice		
Allied Health (Name)		
Address / Practice		
Other (Name)		
Address / Practice		
Signature:		
Date:		

Additions or deletions to this list after the date above should be initialled and dated by the worker.

The personal information collected as a result of this form may be used for the following purposes in relation to this claim only:

- The management of your rehabilitation/suitable duties plan;
- To facilitate your safe return to work; and
- To provide any on-going workplace support services as required.

Your personal information will not be disclosed to any person or agency without your express consent. Your personal information may be disclosed to a health care professional in relation to the above purposes only. The personal information collected will not be included in your personnel file.

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