Medical Authorisation Form

WHS-PRO-FORM-006c

Electronic copies of this form are current. All other copies are uncontrolled and currency can only be assured at the time of printing

I,_____(name), _____ (date of birth), hereby give my consent for the following specified treatment providers to discuss with James Cook University's Injury Prevention and Management Advisor, the medical information relevant solely to this specific injury management for the sole purpose of assisting with my workplace rehabilitation and my safe return to work.

Treating Doctor/s (Name)	
Address / Practice	
Medical Specialist (Name)	

Address / Practice

The personal information collected as a result of this form may be used for t
this claim only:

The management of your rehabilitation/suitable duties plan;