Medical Authorisation Form

WHS-PRO-FORM-006c

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	
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.