

## Injured worker authorisation

I (name) \_\_\_\_\_ date of birth \_\_\_\_\_ of  
(address) \_\_\_\_\_ hereby give my consent for the following  
specified treatment providers to discuss with my employer's rehabilitation and return to work coordinator  
(name) \_\_\_\_\_, the injury information relevant solely to this  
specific workers' compensation claim for the sole purpose of assisting with my rehabilitation/suitable duties plan for  
this injury and my safe return to work.

Treating doctor (name): \_\_\_\_\_

Address: \_\_\_\_\_

Medical specialist (name): \_\_\_\_\_

Address: \_\_\_\_\_

Physiotherapist (name): \_\_\_\_\_

Address: \_\_\_\_\_

Occupational Therapist (name): \_\_\_\_\_

Address: \_\_\_\_\_

Chiropractor (name): \_\_\_\_\_

Address: \_\_\_\_\_

Other (name): \_\_\_\_\_

Address: \_\_\_\_\_

Other (name): \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Worker)

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

1. the management of your rehabilitation/suitable duties plan
2. to facilitate your safe return to work; and
3. 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.