THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

Form No. 1
Treating Practitioner's/ Provider's Release Authority

RELEASE AUTHORITY

(name) _____

(address) _____

_____

I hereby authorise any doctor, health authority, allied health provider, rehabilitation provider or other insurer to disclose to Work Injury Management any information regarding my medical history. I also authorise the following doctors/providers who are treating or who have treated me to provide The University of Queensland Case Manager/Rehabilitation Coordinator with verbal/ written reports or clinical notes relating to this or similar related conditions, which they may request for the purpose of:

- **determining my compensation**
- **rehabilitation purposes**

I agree that a photocopy of this authorisation can be accepted with the same authority as the original.

Name, address and phone number of treating practitioner/provider:

Name, address and phone number of treating practitioner/provider:

Name, address and phone number of treating practitioner/provider:

Name, address and phone number of treating practitioner/provider:

Signature of applicant: _____ **Date:** _____

111090/20November2018