SPECIALIST PLUS

Consent Form

Given Names:	Surname:
Preferred Name:	Date of Birth:
Address:	
Address:	
Phone Number:	Email:
Medicare Number:	Reference Number: Expiry:
Insurer (i.e. EML):	Claim Number:
Date of Injury:	Claim Manager:
Allergies:	
Do you drink Alcohol? Alcohol Consumption Per Week:	Do you smoke? Cigarettes per Day: Years Smoked: Quit Smoking Date:
Medications	
Name	Dosage

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Patient Authority

Your authority for the release and collection of medical information

I authorise and consent to any health professional, legal representative, rehabilitation provider, case manager and Specialist Plus providers disclosing, releasing, or discussing records containing my personal medical information, between one another. I understand that the medical information is required for the purposes of determining and managing my compensation claim, to assist with my treatment.

I authorise and consent to a photocopy of this Authority being sufficient evidence of my authority and consent to discuss or provide the medical information requested.

Do Not Consent:

Enter Your Full Name As A Signature:

Date Signed: