

[illegible]



SPECIALIST PLUS

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.

Patient Authority:

Consent:

Enter Your Full Name As A Signature:

Date Signed: