THE PAIRATAHI TRUST

Confidential

Authority to Release Medical Information/Consent – Form

Name: _____

Address: _____

_____

_____

Date of Birth: ____/____/____

Phone number:_____

I hereby authorise you to release to my employer THE PAIRATAHI TRUST, all relevant medical information about my injury (date:____/____/____) to assist in my rehabilitation in the workplace. This information may be provided to other medical professionals and an ACC Case Supervisor if necessary.

I understand that this consent is required to assist with my rehabilitation and return to work, and that all information obtained will be treated in confidence, and only for the purpose of rehabilitation. This consent is only valid for the duration of my rehabilitation programme.

I understand that I have the right to access, and ask for correction of any information my employer holds about me.

Signed by the injured employee:

_____

Date: _____

Signed by Supervisor (or designate) as witness:

_____