



## MEDICAL AUTHORITY

I, \_\_\_\_\_ of \_\_\_\_\_

authorise any medical expert to release and provide to my employer any information relating to my injury to the \_\_\_\_\_ suffered on \_\_\_\_/\_\_\_\_/\_\_\_\_ whilst employed with \_\_\_\_\_.

I authorise any medical expert nominated by my employer to receive and examine any x-rays, medical records or reports, or copies thereof, relating to my injury and treatment, in order to prepare and forward a report to my employer.

I authorise my employer and an external rehabilitation provider where involved, to release to each other any medical reports obtained or prepared in relation to my injury.

I authorise my employer and any of its authorised officers to obtain the above information for the purpose of managing my compensation claim and/or my rehabilitation programme and/or my rehabilitation and return to work plan.

I direct that a photocopy of this medical authority shall be considered as effective and valid as the original.

I acknowledge that a copy of any medical report obtained by my employer will be forwarded to me.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_