Information Authority

For the collection of personal and health information

Name _____ *(print full name)*

Employer _____

Date of Birth _____ Claim Number _____

My personal and health information will be collected by StateCover to effectively manage my injury, recovery at work and workers compensation claim.

I understand that:

- I may change, limit or cancel this authority at any time in writing.
- My compensation benefits may be affected if I cancel or withdraw this authority.
- I may access my personal and health information as per the Australian privacy principles and laws, by making a request in writing to StateCover.
- My authority has effect for the duration of this claim.

Authorisation and consent

I authorise and consent to the collection, disclosure, use and exchange of any personal and health information in connection with my injury/condition to which the claim relates, by StateCover, my employer, the State Insurance Regulatory Authority (SIRA) or to any person who provides me with medical, hospital, treatment or rehabilitation services.

I authorise and consent to any person who provides me with medical, hospital, treatment or rehabilitation services in connection with my injury/condition will provide to StateCover, upon their request, any information regarding those services provided to me.

Signature of Worker _____ Date _____

Interpreter _____ *(print full name)*

Signature of Interpreter _____ Language _____

A photocopy of this authority shall be valid as the original.

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