

# Information Authority

For the collection of sensitive information



Full name \_\_\_\_\_

Employer \_\_\_\_\_

Date of birth \_\_\_\_\_ Claim number \_\_\_\_\_

StateCover Mutual will collect my personal and health information to effectively manage my injury, recovery at work, and workers compensation claim.

I understand that:

- I may change, limit or withdraw this authority at any time in writing
- My compensation benefits may be affected if I cancel, limit 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, subject to certain limitations
- My authority has effect for the duration of this claim.

## Authorisation and consent

I authorise and consent to the collection, processing, and disclosure of my sensitive information, including health information, in connection with or relevant to my injury or condition. This consent applies to StateCover, my employer, the State Insurance Regulatory Authority (SIRA), and any person or organisation providing me with medical, hospital, treatment, or rehabilitation services/products.

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

Worker signature \_\_\_\_\_ Date \_\_\_\_\_

Interpreter language (if needed) \_\_\_\_\_

Interpreter full name \_\_\_\_\_ Signature \_\_\_\_\_

Please email this signed authority to [claims@statecover.net.au](mailto:claims@statecover.net.au).

This form may be signed electronically. A copy, scan, or electronic version of this authority has the same force and effect as the original.