Standard consent form for release of personal information

State Insurance Regulatory Authority

Worker details			
Claim number			
Given name(s)		Surname	
Employer details			
Organisation			
Contact name		Position	
Phone		Email	

Worker's declaration

I have discussed this consent form with my employer. I understand that any information collected will be kept in a confidential case file, with access restricted to those who are directly responsible for coordinating and monitoring my recovery at work.

I understand that my employer will:

- only collect health information that is relevant and necessary to manage my recovery at work and coordinate the workers compensation claim
- only use and disclose information for the purpose for which it was collected
- keep any information collected separate from my other personnel records
- take reasonable steps to protect my information by ensuring it is stored securely, kept no longer than necessary and disposed of appropriately
- allow me to access my information without unreasonable delay, unless providing access would be unlawful or pose a serious threat to another person's life or health.

Considering the above, I authorise and consent to the collection, use and disclosure of personal and health information relevant to managing my injury and workers compensation claim.

This information may be exchanged between my employer, my treating doctor(s), the insurer, the workplace rehabilitation provider and the State Insurance Regulatory Authority (SIRA).

I understand that my workers compensation entitlements may be affected if I withdraw my consent.

Worker			
Signature		Date	
Employer representative			
Signature		Date	
Interpreter			
Signature		Date	
Name			