



## **STATECOVER MUTUAL LIMITED**

### **INFORMATION AUTHORITY**

I.....(name) of..... (employer)

authorise StateCover Mutual Limited and / or an appropriate representative of my employer to obtain and release information, either verbal or written, in relation to my work-related injury and subsequent claim for compensation.

I have nominated the following agencies as currently being involved with my claim and injury management:

- i. Nominated treating doctor: .....
- ii. Hospital or specialist medical personnel: .....
- iii. Rehabilitation Provider: .....
- iv. Union: .....
- v. Other: .....

I authorise this information to be exchanged concerning relevant aspects of my case, in order to assist in the management of my return to work and active medical management.

I understand that I may change or cancel this authority at any time and that I am able to limit the authority of any of the parties to disclose information at any time in writing. However I understand that my compensation benefits may be affected if I do not cooperate fully in the development and implementation of a StateCover Injury Management Plan.

I direct that a photocopy of this Information Authority will be accepted with the same authority as the original.

Signature: ..... Date: .....

Signature of interpreter: ..... Name: .....