ARGYLE MEDICAL CENTRE
5 FENWICK CRESCENT
GOULBURN NSW 2580
TELEPHONE: (02) 4821 1188
FAX: (02) 4821 9111
argylemc@bigpond.net.au

AUTHORITY TO OBTAIN/RELEASE PERSONAL INFORMATION

Name: _____

Address: _____

Contact Number: _____

Date of Birth: _____

Email Address: _____

Give permission for release of information to:

Treating Doctor	Other Treating Parties
Insurance Agent/Broker	Employer
Workcover	Lawyers / Solicitors

Prospective Employers (cross out if not required)

Training Providers (cross out if not required)

any information, which is relevant to my Workers Compensation Claim.

I fully consent to my doctor releasing information to and discussing my care and relevant medical records with the person named above.

This authority is for an indefinite period / for a limited period only (delete as appropriate)

Where a limited period applies, this authority is valid until ..... (insert date)

I understand that the information will be respected as confidential and handled accordingly.

Signature _____

Print Name _____

Date _____