Injured Worker Authorisation

I (name)		date of birth		of
(address)		hereby give my consent for the following		
specified treatment providers authorisation to discuss with my employer's Injury Management Consultant				
(name)		the injury information relevant solely to this		
specific *non-work related injury / illness* for the sole purpose of assisting with my return to work plan.				
Treating doctor (name):				
Address:	Phone			
Medical specialist (name):				
Address:	Phone			
Physiotherapist (name):				
Address:	Phone			
Occupational Therapist (name):				
Address:	Phone			
Chiropractor (name):				
Address:	Phone			
Other (name):				
Address:	Phone			
Other (name):				
Address:	Phone			