Smart Health
Training & Services

Your health care team.

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Physiotherapy
Pilates
Massage
Chiropractic
Paediatrics
OH&S
Dietetics

AUTHORITY TO RELEASE/OBTAIN INFORMATION

As part of your treatment we may need to discuss confidential information relevant to your injury with your doctor, medical provider/s, lawyer, employer, claims manager and in some instances other people/organisations. By completing this authority to release/obtain information you are giving permission to release/obtain information relevant to the management of your rehabilitation and/or return to work.

I (name)……Date of Birth …….

Of (address)……..

Authorise Smart Health Training & Services obtaining and giving information, both verbally and in writing, to/from other Health Professionals pertaining to the medical conditions, where relevant, to the assessment/treatment being received at Smart Health Training & Services. Please indicate the people below: *(For general authority, please tick the box provided .**To limit authority**, write the names of people/ organisations you are authorising on the line)*

□ Assessing and treating medical doctors (eg. GP, Occ.Physician).....

□ Assessing and treating medical providers (eg, Physio, Radiologist).....

□ Lawyer.....

□ Employers.....

□ Other (eg, union representative, case manager).....

I approve a copy of the authority being treated as the original. The authority is valid for the duration of involvement with Smart Health Training and Services, and only superseded by a new authority or until such time as either myself or my representative revokes the authority.

Client's Signature: _____

Therapist's Signature: _____

Date: _____