



Medical Information Disclosure Authority

I, Mr / Mrs / Ms
(Given name/s) (Family name)

of

authorise any Medical Practitioner, the Officer in Charge of any Hospital or any other persons/entities to give the **Insurance Commission of Western Australia** or its Solicitor any medical information and/or documents regarding the crash I was involved in on theday of20.....and any other relevant medical/personal information relating to me.

I also authorise the Insurance Commission of Western Australia providing to any persons and/or entities, information and/or documents containing relevant medical and other personal information relating to me for the purposes of assessing, determining and arranging the necessary and reasonable treatment, care and support required by me.

This authority is to remain valid unless revoked or the claim is finalised.

Dated the day of 20

Signed

Where an injured person signing this form is under the age of 18 years, a clinician/medical practitioner must sign the following statement:

I confirm that the injured person understands the effect of signing this Medical Information Disclosure Authority and has the necessary capacity to give the above authority.

Name of clinician/medical practitioner.....

Signature of clinician/medical practitioner.....

Date.....

IF YOU ARE UNABLE TO INSERT A DIGITAL
SIGNATURE TYPE NAME HERE