icare™
Dust Diseases Care

Release Form

Authority by Next of Kin to Release Medical Records

Dust Diseases Care requires access to all the deceased worker's medical records to determine your application. Please complete this authority form to allow Dust Diseases Care to access those records.

1. Details of deceased worker

First name

Middle name

Surname

Date of birth

Date of death

Address (street & number)

Suburb/Town

State

Post code

Country

2. Your authority

I authorise any medical practitioner, hospital, health care professional or service provider who had treated or examined the deceased worker to give Dust Diseases Care access to any of the deceased worker's medical records to assist in the proof and settlement of my compensation claim. A photocopy of this authority form can be acted upon as if it were the original.

3. Details of next of kin

First name

Middle name

Surname

Address (street & number)

Suburb/Town

State

Post code

Country

Home telephone

Mobile

Relationship to the deceased worker

Signature of next of kin

Date

Office use only

DDC File number

Date Received