icare™
Dust Diseases Care

# Release Form

## Authority to Release Medical Records

Dust Diseases Care requires access to your medical records to determine your application. Please complete this authority form to allow Dust Diseases Care to access those records.

### 1. Your details

First name

Middle name

Surname

Date of birth

Address (street & number)

Suburb/Town

State

Select State

Post code

Country

Home telephone

Mobile

### 2. Your authority

*I authorise any medical practitioner, hospital, health care professional or service provider who had treated or examined me to give Dust Diseases Care access to my 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.*

Signature

Date

**Office use only**

DDC File number

Date Received