|  |  |
| --- | --- |
|  |  |
| To: |  |
| Worker’s Last Name: |       |
| Worker’s Given Names: |       |
| Date of Birth: |      /     /      |
| Address: |       |
|       | Suburb: |       |
| State: |       | Postcode: |       |

Please treat this letter as a formal request and authority to release information to Hotel Employers Mutual Limited in respect to my claim history including clinical notes, radiography reports, hospital notes and treatment related documents, which they may request from you.

A photocopy of this authority shall be sufficient authority without production of the original.

I agree to allow the insurer to have a copy of all or part of the clinical notes and I am aware that clinical notes or part thereof will inevitably include confidential medical information which may be irrelevant to the claim.

|  |  |
| --- | --- |
| Signed |       |
| Print Name: |       |
| Date: |      /     /      |
| Witness Name: |       |
| Witness Signature: |       |

**Please complete and sign this document and return the form to Hotel Employers Mutual:**

**🖃:** GPO Box 4143, SYDNEY NSW 2001

**🖂:** info@hotelemployersmutual.com.au

**:** 02 8351 9495