

MEDICAL AUTHORITY FORM NEXT OF KIN

I hereby authorise _____

to forward to the Senior Specialist Medical Officer of the Workers' Compensation (Dust Diseases) Board copies of my medical records including but not limited to the following:

- Doctors' reports
- Discharge summary
- Medical records/Clinical notes
- Histopathology/Cytopathology
- All chest x-rays/CT scans
- Spirometry/Lung function
- Pathology review
- Further testing
(e.g. fibre count)
- Medical Certificate of Cause Death
- Other Please specify _____

Worker's Name (please print) _____

Address _____

_____ Postcode _____

Date of Birth

D	D	M	M	Y	Y

PLEASE SIGN AND DATE THIS SECTION

Next of Kin's Signature _____

Next of Kin's Name (please print) _____

Relationship to Worker _____

Date

D	D	M	M	Y	Y