# Workplace rehabilitation: voluntary medical authority

As set out in the Department of Education’s (the department) *Workplace Rehabilitation* procedure and the *Information Privacy Act 2009*, your Rehabilitation and Return to Work Coordinator needs your consent to contact your treating medical practitioners and health care providers, as well as WorkCover and QSuper (or other insurer) where relevant, in order to obtain and discuss information about your current injury/illness, diagnosed as \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for the purposes of your workplace rehabilitation program. The information may include sensitive or confidential health information.

The information will only be used for the purpose of your workplace rehabilitation. Workplace rehabilitation focuses on your return to work and emphasises interventions, including modified hours, duties or relocation, aimed at maintaining you within the workplace or assisting your return to other appropriate employment. If you are unable to return to your substantive position, transfer, deployment/redeployment, or ill health retirement may be considered by the department as part of your workplace rehabilitation.

The information will be maintained in confidence and stored securely. With your consent, the Rehabilitation and Return to Work Coordinator may disclose information to your treating medical practitioners and external rehabilitation providers involved in your workplace rehabilitation.

However, the information may be disclosed by the Rehabilitation and Return to Work Coordinator without your consent where authorised or required by law. This may include disclosure to WorkCover, QSuper (or other insurer) or doctors appointed by the department for the purposes of advising the department in relation to rehabilitation, transfer, deployment/redeployment, or ill health retirement.

Additionally, information relevant to the impact that your injury/illness has upon your work may be discussed confidentially with your workplace supervisors, Regional or Central Office Organisational Health or Human Resources employees without your consent.

**Authority**

Please tick the boxes below as appropriate to indicate whether you consent to the listed activity in relation to information (which may include sensitive or confidential health information) relevant to your current illness/injury (‘*your information’*) for the purpose of your workplace rehabilitation.

|  |  |  |  |
| --- | --- | --- | --- |
| **Activity** | **Yes** | **No** | **Not Applicable** |
| Do you consent to **WorkCover** disclosing your information to the department’s appointed Rehabilitation and Return to Work Coordinator? | 🗌 | 🗌 | 🗌 |
|  |  |  |  |
| Do you consent to **QSuper** (or other insurer) disclosing your information to the department’s appointed Rehabilitation and Return to Work Coordinator? | 🗌 | 🗌 | 🗌 |
|  |  |  |  |
| Do you consent to the **medical and health care providers listed in the attached Schedule** disclosing your information to the department’s appointed Rehabilitation and Return to Work Coordinator? | 🗌 | 🗌 | 🗌 |
|  |  |  |  |
| Do you consent to the Rehabilitation and Return to Work Coordinator disclosing your information to **treating medical practitioners and external rehabilitation providers involved in your workplace rehabilitation**? | 🗌 | 🗌 | 🗌 |

*(A photocopy of this consent form may also be accepted with the same authority as the original)*

**Signatures:**

Employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Names (Please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

**Schedule: Medical authority**

*(Use in conjunction with ‘Voluntary medical authority’. See ‘Voluntary medical authority’ for privacy information.)*

**Authority**

I authorise the medical practitioners and health care providers below to disclose information (which may include sensitive or confidential health information) relevant to my current illness/injury to the appointed Rehabilitation and Return to Work Coordinator of the Department of Education.

Note: The range of health care providers may include, but is not limited to medical specialists, allied health professionals and therapists. If insufficient room, attach another page and ensure that it is signed and witnessed as below.

|  |  |  |
| --- | --- | --- |
| **Medical Practitioner** | **Address** | **Telephone** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

*(A photocopy of this consent form may also be accepted with the same authority as the original)*

**Signatures**

Employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Names (Please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

For further information about your privacy and the rehabilitation process, please contact the Department of Education, Organisational Safety & Wellbeing via email InjuryManagement@qed.qld.gov.au or at <https://education.qld.gov.au/initiatives-and-strategies/health-and-wellbeing/workplaces>.