AUTHORITY

I _____

of _____

Date of Birth _____

Hereby authorise my employer **Toll Holdings**[1] and its authorised delegates to contact and obtain information (either verbal or written) in relation to my workplace injury that occurred on:

Date of Injury _____

This information will be obtained, for the purpose of Rehabilitation and Return to Work, from doctors, specialists, health professionals, rehabilitation providers, insurance companies or previous employers and for said parties to release information, to my employer **Toll Holdings**[1] and its authorised delegates, relevant to my workplace injury, including full copies of medical reports from my treating medical practitioners and other health professionals, who have examined me in relation to my workplace injury.

A photocopy of this Authority shall be as valid as the original thereof.

As per Toll Group Policies[2], Toll will only use collected data for the purpose for which it was collected or for related purposes.

Date _____ **Signature** _____

[1] Toll Holdings and its subsidiaries
[2] Toll Group Privacy Policy Toll Group Workplace Rehabilitation Policy