



THE UNIVERSITY OF  
**WESTERN  
AUSTRALIA**

**AUTHORITY TO OBTAIN/RELEASE INFORMATION**

I, \_\_\_\_\_ of \_\_\_\_\_  
authorise my General Practitioner/s to provide:

1. Name ( Position/title ) with information in relation to my health/medical condition as it pertains to my work at the University of Western Australia

\_\_\_\_\_  
(Signature)

Date: