Medical Withdraw Consent Form

I [Full Name]_____rescind any consent which I previously provided for the collection and/or release of my medical or other personal and private information by or to any party including:

- [Insert Employer name]_____ Injury Management Team and/or Company Representatives
- [Insert Employer name)_____ Injury Management Coordinator
- [Insert Employer name]_____nominated RTW / IM Provider
- [Insert Employer name)_____ Insurance Policy Holder Representatives

_____ _____

Signature Date