

Dental Injury Claim Form XX12345



PART D: INJURY DIAGNOSIS AND PRE-ACCIDENT CONDITION

Patient to	o complete	History: When Examination: Face	/Where/How, possible lacera	istory taking and examination head/neck injury, pain with eat tion/abrasion/contusion, palpa	te facial skeleton/TMJ/chir	in	
PARTA: F	ERSONAL DETAILS	Teeth	- fractured ename	a/mucosa/lip, gingival crevice b el or enamel/dentine, pulp expo e/direction, occlusion, palpation	sed, root involved, transill		
Family name	SURNAME	Tests Diagnosis – enter	percus	ssion, mobility, pulp tests, radic ry Classification <i>(Use 191Z.)</i>		Pre-Accident Condition	
First name(s)		tooth number (one per line), tick				in the second	
Date of birth	DAY MONTH YEAR Male Female	relevant diagnosis (multiple, if applicable) and pre-accident		je		scining set state the the state stat	
Home/postal address		condition.	of the solution of the solutio	acture son ion union union union	eladion constant and a constant and		
Telephone WORK	SUBURB TOWN/CITY OCODE CODE CODE	Tooth Number 470 40	traine Court Contract	St ond citie to the state	Ruber No office of Orion	Jee Jeen Micro Perio Perio Additional Injury Comment	
What is your ethnic l	packground? This information is collected for statistical reasons only, to help ACC develop services that are culturally appropriate.						
NZ European/Pa	keha Ocok Island Māori Fijian Indian Osamoan Other ethnic group - please specify						
Other European	Tongan Other Pacific Other Asian Tokelauan						
🔵 NZ Māori	Niuean South East Asian Chinese I'd prefer not to say						
PART B: A	CCIDENT & EMPLOYMENT DETAILS						
When did the accide		Prosthesis damage?	(Use SPo47)	Was the prosthesis	being worn at time of injury	ry? 🔿 Yes 🔿 No	
	DAY MONTH YEAR TIME	Type (describe):				Have you sighted the denture? 🔷 Yes 🔷 No	
Accident scene (eg. home, place of wor	k, road)	List teeth on partial o	enture:				
Accident location (eg. Taupo)	Did the accident occur in New Zealand? Yes No	Soft Tissue Gingiva	How: Iaceration	abrasion contu	sion Position in mouth	h.	
What were you doin	g – what happened – how was the injury caused? (eg. cleaning kitchen, slipped on wet floor and hit head on table)		How: Olaceration	abrasion Contu			
			How: Iaceration	abrasion Contu			
		Degloving injury	(Use S837.)	lower labial sulcus	upper labial s		
Did the accident invo vehicle on a public r	blve a moving motor bad, driveway or beach? Yes No If sporting injury, name sport (eg. rugby union)	Jaw/Alveolus/TMJ		-			
Occupation		Alveolar socket #	(Use So2)	Alveolar process #	Teeth involved:		
Please tick those tha	it apply: O Low is sold employment	🔵 Maxilla #	(Use So2)	O Mandible #	Type/position:		
	(part time or full time) I awn/part own the I am self-employed I am not in paid employment company in which I work	C Left side TMJ inju	у	Right side TMJ injury	Describe specific inju	µry:	
What type of work do			ated to dental injury cl	<u> </u>			
(Tick one box only) Did the accident occi	(brief standing and walking) (mainly standing and walking) (often lift 5kg plus) (often lift 9kg plus) (often lift 22kg plus)		sing prior to accident?	Yes No Please li			
What is the name of t		Assessment of oral h Assessment of period		Good Fair	O Poor O Poor		
you are employed by		Assessment of caries		Little or none Mode	-		
What is the address of you are employed by/	nwo?	Radiographs taken?		Type:	<u> </u>	Photographic record of injury? Yes No	
	EMPLOYER NAME AND ADDRESS						
_	ATIENT AUTHORISATION AND DECLARATION		EFERRAL AND				
	r dental claims with ACC before? Yes No an Injury Claim Form for this accident with another treatment provider? Yes No	Are there more exten Consider referral for	Sive injuries? Ore	es \bigcirc No \bigcirc Not sure	Is this claim	n for treatment injury? Yes No (if Yes, please fill in ACC2152)	
	an Injury Claim Form for this accident with another treatment provider? Yes No ury Claim Form number?	bleeding fr	om nose or ear / doubl	e vision / abnormalities when p		/ crepitus / areas of paraesthesia / neck pain	
				(eg. Oral & maxillofacial surgeo	_		
	the Important Information and the Patient Authorisation and Declaration on the reverse of the patient copy of this form.			nanagement or home help) Yes		ACC should call me? OYes No	
Patient to sign here guardian or represen				OVIDER DECLARATIO			
Authorised		I certify that, on the d I also certify that the	ate shown, I have perso patient (or their represe	onally examined the patient and entative) has signed the Patient /	that in my opinion the con Authorisation and Declarat	ndition is the result of an accident. tion and has authorised me to lodge the claim on their behalf.	
representative's nar		Treatment provider name (print) or stam				Provider number	
Authorised represen relationship to patie		Treatment provider	×			Practice Vendor ID	
	lited Employer copy: Please return this form when completed to your ACC Service Centre or	signature Health Practitioner	••	G	F	Date	
to the Accredi	ted Employer (check www.acc.co.nz)	Index	PERSON (CPN)			DAY MONTH YEAR	

October 201	00	to	ber	20	1
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Treatment Provider to complete

(Note: ACC does not provide cover for damage that results from natural use of teeth or disease)

Important Information

PATIENT You and ACC working together

This form is the first step in getting help from ACC if you have been injured in an accident. ACC does not provide cover for damage arising from disease or the natural use of teeth such as biting or chewing (this includes any foreign body contained in the food). This form collects the basic information we need about your injury to help us decide if we can provide cover. If we need more information about this claims we will contact you later.

ACC is here to help when you've suffered an injury. Once cover has been established (that means that you have an injury which ACC has accepted) we'll help towards the cost of your accident-related dental treatment. This means it's important that all the information on this Dental Iniury Claim Form (ACC42) is accurate. You should also let ACC know about any change in your circumstances. The information you provide helps us to make sure you receive the right treatment and payments for this claim.

ACC will pay a fee direct to your treatment provider for your initial dental and/or medical treatment. Your treatment provider may have charged you an extra amount (surcharge) above the amount that ACC can pay. We are not able to reimburse you for that surcharge.

ACC may be able to assist you with other types of help depending on your needs. But you must apply for this assistance. Please contact us on o8oo 101 996 to get our approval before you incur costs that you expect ACC to pay.

You can apply for the following types of assistance:

- medical assistance, including medical treatment, dental treatment, further courses of treatment and travel to treatment
- social rehabilitation assistance to help restore your independence, such as home help, childcare, attendant care, a wheelchair, home modification and education support
- vocational rehabilitation assistance to help you keep your job, find a new job or regain vocational independence. This support can include such things as assessments of your vocational needs, modifications to your work site, work trials and assistance with finding a new job
- financial assistance, such as weekly compensation, or lump sum compensation.

This form may be used by your employer if they are part of ACC's Accredited Employer Programme. In these cases where ACC is specified in the patient declaration, this should be read as applying to the accredited employer managing your claim.

If you would like to know more about the claims process or any other ACC service, please call 0800 101 996.

Collecting your medical and other records PATIENT

Why we ask for your authority to collect your medical and other records

To establish cover and/or assess your entitlement to compensation, rehabilitation and treatment, we may need to collect medical and other records about you from a third party, such as your General Practitioner (GP), other medical professional, employer, or other government agencies. We need your authority to collect them.

These records could include:

- medical reports
- details of your accident
- medical history relevant to your claim
- specialist reports and assessments
- your employment details and history
- income and tax records.

In each case, we'd only seek records that are or may be relevant to your claim during the life of your claim.

We'll comply with the Privacy Act 1993, the Health Information Privacy Code 1994 and the Accident Compensation Act 2001 when collecting, using and managing personal information. You have the right to access any information we hold about you. You can also ask us to correct the information we hold about you.

For more details see ACC's privacy notice at www.acc.co.nz/privacy.

PATIENT AUTHORISATION AND DECLARATION

l authorise:

- ACC to collect medical and other records which are or may be relevant to my claim
- the treatment provider to lodge this claim for me.

I declare:

• that the information I have given in this form is true and correct.



Dental Injury Claim Form XX12345

	PART D: INJURY DIAGNOSIS AND PRE-ACCIDENT CONDITION results from natural use of teeth or disease)
Patient to complete	The following are checklists to help in the history taking and examination History: When/Where/How, possible head/neck injury, pain with eating/cold, occlusion altered Examination: Face laceration/abrasion/contusion, palpate facial skeleton/TMJ/chin Intra-oral soft tissues gingiva/mucosa/lip, gingival crevice bleeding, sublingual ecchymosis, degloving
PART A: PERSONAL DETAILS	Teeth – fractured enamel or enamel/dentine, pulp exposed, root involved, transilluminate – displaced degree/direction, occlusion, palpation
Family name	Tests percussion, mobility, pulp tests, radiographs Diagnosis - enter tooth number Teeth Injury Classification (Use 191Z.) Pre-Accident Condition
First name(s) Date of birth Male Female	(one per line), tick relevant diagnosis (multiple if
Home/postal address	applicable) and pre-accident condition. $\int_{-\infty}^{\infty} \int_{-\infty}^{\infty} \int_{-\infty}^{\infty}$
Address NUMBER STREET NAME	applicable) and pre-accident condition. Tooth Number transfer Number transfer
What is your ethnic background? This information is collected for statistical reasons only, to help ACC develop services that are culturally appropriate.	
○ NZ European/Pakeha ○ Cook Island Māori ○ Fijian ○ Indian ○ Samoan ○ Other ethnic group - please specify	
Other European Tongan Other Pacific Other Asian Tokelauan	
NZ Māori Niuean South East Asian Chinese I'd prefer not to say	
PART B: ACCIDENT & EMPLOYMENT DETAILS	
When did the accident happen?	Prosthesis damage? (Use SP047) Was the prosthesis being worn at time of injury? Yes No Type (describe): Have you sighted the denture? Yes No
Accident scene	List teeth on partial denture:
(eg. home, place of work, road) Accident location Did the accident occur in New Zealand?	Soft Tissue
Accident location (eg. Taupo) Did the accident occur in New Zealand? Yes No	Gingiva How: Olaceration Oabrasion Ocontusion Position in mouth:
What were you doing – what happened – how was the injury caused? (eg. cleaning kitchen, slipped on wet floor and hit head on table)	Mucosa How: Olaceration Oabrasion Ocontusion Position in mouth:
	Lip How: Olaceration Oabrasion Ocontusion Position in mouth:
	Degloving injury (Use S837.) O lower labial sulcus O upper labial sulcus
Did the accident involve a moving motor If sporting injury, name sport vehicle on a public road, driveway or beach? Yes No (eg. rugby union) (eg. rugby union)	Jaw/Alveolus/TMJ
vehicle on a public road, driveway or beach? () Yes () No (eg. rugby union) ' ' ' Contraction	Alveolar socket # (Use So2) Alveolar process # Teeth involved:
	Maxilla # (Use So2) Mandible # Type/position:
Please tick those that apply: I am in paid employment I own/part own the company in which I work I am self-employed I am not in paid employment	Left side TMJ injury Right side TMJ injury Describe specific injury:
What type of work do you do? (Tick one box only) Sedentary (brief standing and walking) Light (mainly standing and walking) Medium (often lift 5kg plus) Heavy (often lift 9kg plus) Very Heavy (often lift 2kg plus)	Other information related to dental injury claim Permanent teeth missing prior to accident? Yes No Please list:
Did the accident occur at work? Yes No	Assessment of oral hygiene O Good O Fair O Poor
What is the name of the business you are employed by/own?	Assessment of periodontal condition O Good O Fair O Poor
What is the address of the business you are employed by/own?	Assessment of caries activity in mouth Little or none Moderate Extensive Radiographs taken? Yes No Type: Photographic record of injury? Yes
EMPLOYER NAME AND ADDRESS PART C: PATIENT AUTHORISATION AND DECLARATION	PART E : REFERRAL AND ASSISTANCE
Have you lodged any dental claims with ACC before? () Yes () No	Are there more extensive injuries? Yes No Not sure Is this claim for treatment injury? Yes No (if Yes, please fill in ACC2152)
Have you completed an Injury Claim Form for this accident with another treatment provider? \bigcirc Yes \bigcirc No	Consider referral for further treatment if sign(s) of the following:
If yes, what is the Injury Claim Form number?	bleeding from nose or ear / double vision / abnormalities when palpatating face / trismus / crepitus / areas of paraesthesia / neck pain
I have read and understood the Important Information and the Patient Authorisation and Declaration on the reverse of the patient copy of this form.	Referred to other type of treatment provider (eg. Oral & maxillofacial surgeon, Neurologist, Orthodontist): Rehabilitation/assistance required? (eg. case management or home help) Yes No ACC should call me? Yes No
Patient to sign here or legal guardian or representative	PART F: TREATMENT PROVIDER DECLARATION
DAY MONTH YEAR	I certify that, on the date shown, I have personally examined the patient and that in my opinion the condition is the result of an accident. I also certify that the patient (or their representative) has signed the Patient Authorisation and Declaration and has authorised me to lodge the claim on their behalf.
Authorised representative's name	Treatment provider
Authorised representative's relationship to patient	name (print) or stamp
	Treatment provider signature Practice Vendor ID
Treatment provider copy: Please retain this copy for your patient's file. For further assissiance, call ACC Provider helpline on 0800 222 070.	Health Practitioner Index G G F G G G G G G G G G G G G G G G G

Treatment Provider to complete

(Note: ACC does not provide cover for damage that

Important Information

TREATMENT PROVIDERS

This form is the first step for your patient in getting help from ACC if they've been injured in an accident. ACC does not provide cover for damage arising from disease or natural use of teeth, such as biting or chewing (unless it involves a foreign body, e.g. piece of stone).

Please make sure that all of the information you provide on this form is accurate, and that the patient information is completed in full. Do not complete this form if your patient has already completed a Dental Injury Claim Form (ACC42) for this particular injury. To obtain a previous claim number, please contact the ACC Provider Helpline on o800 222 070.

Once cover is established, ACC will help towards the cost of your patient's dental treatment. ACC will not reimburse your patient for any additional charges you may make. (Note: If the patient has not yet lodged a claim for non-dental injuries sustained, they should see a GP where an ACC45 Injury Claim Form can be completed).

ADDITIONAL INFORMATION

Part B: Accident and Employment Details

Please note that if your patient has had a work accident you must determine whether their employer is accredited under ACC's Accredited Employer Programme, You can check the ACC website (www.acc.co.nz) for a list of accredited employers. If the employer is accredited you may send this ACC42 form directly to the employer or send it to ACC and we will forward it to the accredited employer. In either case, you should invoice that employer directly.

Parts C & F: Patient and Treatment Provider Declaration

Once the form has been completed, you must ensure that these sections are dated and signed so that the patient receives cover for their injury and you receive payment.

Part D: Injury Diagnosis and Pre-Accident Condition

ACC uses information collected in this section to obtain a picture of the state of the patient's teeth and mouth at the time of the injury. This helps ACC's assessment of cover as well as the patient's current and future dental treatment.

Generally, if the patient's injured teeth have been weakened by disease or heavily restored then ACC only pays 75% of the regulated price, (unless ACC or an insurer was liable for the previous work).

In the case of previous crowning work, if ACC or an insurer was not liable, then ACC pays only 50% of the regulated price for crowns.

The History and Examination section has a series of points to check against the patient's condition to help make a diagnosis. The tooth that is injured is listed first then a diagnosis of the dento-alveolar injury is made, by ticking the appropriate box. More than one diagnosis per tooth can be made (e.g. concussion and enamel-dentine fracture). A full description of this classification can be found in the *Dento-alveolar Trauma Manual* or in the *Dental Injury Claim Form* (ACC42) Completion Guide. The pre-accident condition of the injured tooth should be denoted by ticking the appropriate box. Prosthesis damage, Soft tissue injury or Jaw/Alveolus/TMJ injury diagnosis is made by ticking the appropriate circle with description where applicable.

Part E: Referral and Assistance

If the patient shows signs of other injuries needing urgent attention, especially head injury, refer the patient for appropriate treatment immediately. Please tick the "ACC should call me" box if this was the case and if you want an ACC case manager to call you to discuss the claim.

ACC may also be able to offer your patient other types of help depending on their individual needs. If your patient is likely to require time off work, rehabilitation or entitlement assistance (other than primary medical treatment and treatment referrals) from ACC please indicate this by ticking the "Rehabilitation/Assistance Required" box. Examples of assistance available are home help, assistance with the cost of transport to treatment, weekly compensation and case management intervention to facilitate a return to work.

If you need any help in completing this Dental Injury Claim Form (ACC42), or any other ACC form, please contact our Provider Helpline on o8oo 222 o7o.

Claims for Treatment Injury

Please complete this ACC Dental Injury Claim Form (ACC42), a Treatment Injury Claim Form (ACC2152) and attach copies of clinical notes that support the claim if relevant.

For your information, here is a copy of the patient authorisation and declaration.

PATIENT AUTHORISATION AND DECLARATION

l authorise:

- ACC to collect medical and other records which are or may be relevant to my claim
- the treatment provider to lodge this claim for me.

I declare:

• that the information I have given in this form is true and correct.



Dental Injury Claim Form XX12345

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Patient to complete	The following are checklists to help in the history taking and examination History: When/Where/How, possible head/neck injury, pain with eating/cold, occlusion altered Examination: Face laceration/abrasion/contusion, palpate facial skeleton/TMJ/chin Intra-oral soft tissues gingiva/mucosa/lip, gingival crevice bleeding, sublingual ecchymosis, degloving
PART A: PERSONAL DETAILS	Teeth – fractured enamel or enamel/dentine, pulp exposed, root involved, transilluminate – displaced degree/direction, occlusion, palpation
Family name	Tests percussion, mobility, pulp tests, radiographs Diagnosis – enter tooth number Teeth Injury Classification (Use 191Z.) Pre-Accident Condition
First name(s)	(one per line), tick
Date of birth	relevant diagnosis (multiple, if applicable) and pre-accident & co ^{to} (multiple, if applicable) and (multiple, if (multiple, if)) (multiple, if (multiple, if (multiple, if)) (multiple, if (multiple, if)) (multiple, if (multiple, if)) (multiple, if) (multiple, if)) (multiple, if) (multiple, if)) (multiple, if) (multiple, if)) (multiple, if)) (multiple, if) (multiple, if)) (multiple, if)) (mu
Home/postal address street NAME	condition
Telephone WORK O_{code} HOME O_{\text{code}}	Tooth Number Co ^{Rel} C
What is your ethnic background? This information is collected for statistical reasons only, to help ACC develop services that are culturally appropriate.	
○ NZ European/Pakeha ○ Cook Island Māori ○ Fijian ○ Indian ○ Samoan ○ Other ethnic group - <i>please specify</i>	
Other European Other Pacific Other Asian Other Asian	
NZ Māori Niuean South East Asian Chinese I'd prefer not to say	
If required you can provide further information in answer to the following	
PART B: ACCIDENT & EMPLOYMENT DETAILS	Prosthesis damage? (Use SP047) Was the prosthesis being worn at time of injury? Yes No
When did the accident happen?	Type (describe): Have you sighted the denture? Yes No
Accident scene (eg. home, place of work, road)	List teeth on partial denture:
Accident location (eq. Taupo) Did the accident occur in New Zealand? Yes No	
	Gingiva How: Iaceration abrasion contusion Position in mouth:
What were you doing – what happened – how was the injury caused? (eg. cleaning kitchen, slipped on wet floor and hit head on table)	Mucosa How: Olaceration Olabrasion Ocontusion Position in mouth:
	Lip How: Olaceration O abrasion O contusion Position in mouth:
	Degloving injury (Use S837.) O lower labial sulcus O upper labial sulcus
Did the accident involve a moving motor vehicle on a public road, driveway or beach? Yes No If sporting injury, name sport (eg. rugby union)	Jaw/Alveolus/TMJ
Occupation	Alveolar socket # (Use So2) Alveolar process # Teeth involved:
Please tick those that apply: (part time or full time) I am in paid employment (part time or full time) I own/part own the company in which I work I am self-employed I am self-employed	Maxilla # (Use So2) Mandible # Type/position: Left side TMJ injury Right side TMJ injury Describe specific injury:
What type of work do you do? Sedentary (Tick one box only) Sedentary (brief standing and walking) Light (mainly standing and walking) (brief standing and walking) (often lift 5kg plus) (often lift 5kg plus) (often lift 5kg plus) (often lift 9kg plus) (often lift 9kg plus)	Other information related to dental injury claim Permanent teeth missing prior to accident? Yes No Please list:
Did the accident occur at work? Yes No	Assessment of oral hygiene O Good O Fair O Poor
What is the name of the business	Assessment of periodontal condition Good Fair Poor Assessment of caries activity in mouth Little or none Moderate Extensive
What is the address of the business you are employed by/own?	Radiographs taken? Yes No Type: Photographic record of injury? Yes No
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Have you completed an Injury Claim Form for this accident with another treatment provider? OYes ONo	Consider referral for further treatment if sign(s) of the following: bleeding from nose or ear / double vision / abnormalities when palpatating face / trismus / crepitus / areas of paraesthesia / neck pain Referred to other type of treatment provider (eg. Oral & maxillofacial surgeon, Neurologist, Orthodontist):
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Patient to sign here or legal guardian or representative	PART F: TREATMENT PROVIDER DECLARATION I certify that, on the date shown, I have personally examined the patient and that in my opinion the condition is the result of an accident.
Authorised	I certify that, on the date shown, I have personally examined the patient and that in my opinion the condition is the result of an accident. I also certify that the patient (or their representative) has signed the Patient Authorisation and Declaration and has authorised me to lodge the claim on their behalf.
representative's name Authorised representative's	Treatment provider Provider number
relationship to patient	Treatment provider Practice Vendor ID
Patient copy: Please retain this copy and read the important information. For further assissiance, call ACC Provider helpline on 0800 101 996.	signature Health Practitioner Index $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$

Treatment Provider to complete

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