AUTHORISATION FOR RELEASE OF INFORMATION

Participant's Full Name

Date of Birth

Postal address

NDIS Number

I understand that this authorisation is voluntary. I understand that my information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164) and/or the state laws. I understand that my information may be subject to re-disclosure by the recipient and that if the organisation or person authorised to receive the information is not a health care professional or service provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records my contain information regarding my mental health, substance use or dependency, or sexuality related information. I further understand that by signing below, I am authorising the release or exchange of these records to the parties named below.

I understand that I may revoke this authorisation at any time by notifying 123 Plan Management in writing, but if I do, it will not have any effect on any actions 123 Plan Management took before it received the revocation.

I hereby authorise 123 Plan Management to (check all that apply):

☐ Exchange with ☐ Release to ☐ Obtain from the parties I have indicated below

I hereby authorise 123 Plan Management to exchange / release / obtain information:

☐ verbally only ☐ in written form only ☐ both verbally and in writing

Person/organisation receiving/communicating the information:

Name

Address

Email

Contact

Authorising Signature:

SIGNED by the PARTICIPANT:)
)
)

Signature of Participant

Print Name

SIGNED for and on behalf of the PARTICIPANT by the CARER:)
)
)

Signature of Carer

Print Name