

Client Consent Form

Client First Name *

Client Surname *

NDIS Number *

- I hereby acknowledge that I am aware and understand that, Care Plan Management may need to collect and disclose personal information to third parties (as a requirement) under The National Disability Insurance Scheme Act (NDIS Act) 2013 to provide an improved level of support in accordance with my Service Agreement with Care Plan Management. *

Our practice Care Plan Management will work closely with other agencies to coordinate the best support for you. This means your informed consent for the sharing of information will be sought and respected in all situations unless:

- we are obliged by law to disclose your information regardless of consent or otherwise;
- it is unreasonable or impracticable to gain consent or consent has been refused; and
- the disclosure is reasonably necessary to prevent or lessen a serious threat to the life, health or safety of a person or group of people.

- I hereby acknowledge that I am aware of my right to withdraw my consent at any time. *
- I hereby nominate that my personal information may be collected from and also disclosed to the agencies or persons listed below: *
- I understand why certain information about me may need to be provided to other service providers in order to coordinate the best support for me. *
- I understand that my provider must comply with relevant privacy laws and I will contact the organisation immediately if I feel that these laws have been breached. *

Signature

Draw signature | Type signature

[Clear](#)

Date *