notia
occupational therapy

# CONSENT TO COLLECT / RELEASE INFORMATION

**NAME**:……**D.O.B**……..……

**ADDRESS:**……

……

**Phone:**
**Mobile:**……..**Home:**……

**Email contact:**……

**CLIENTS CONSENT FOR COLLECTION AND RELEASE OF INFORMATION**

I authorise the collection and release of any information which may be relevant to my illness/injury and to my request for support and /or advocacy.

I understand this authority relates to those individuals / agencies or service providers nominated by me and empowers them to provide the information requested by Notia Occupational Therapy.

I understand that in the collection, use and storage of this information that Notia will at all times comply with the Privacy Act of 1993 and the Health Information Privacy Code of 1994.

I understand that I have the right to access, copy and ask for the correction of any information that Notia holds about me.

I understand that this consent is valid for the period Notia provides assistance/support to me, to a maximum of 24 months.

**NOMINATED INDIVIDUALS / AGENCIES / PROVIDERS**

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**SIGNED:** ……..…… **DATE:** ……..……

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