



## SERVICE USER CONSENT FORM

### RELEASE OF INFORMATION

Consent Form Information

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
POSTCODE: \_\_\_\_\_  
PHONE: \_\_\_\_\_ D.O.B: \_\_\_\_\_

#### RELEASE OF INFORMATION:

I \_\_\_\_\_ hereby give permission for staff of  
(Service User / Person Responsible / Legal Guardian)  
FLINTWOOD Disability Services Inc., to release information to the following services:

Residential Service : \_\_\_\_\_  
(Name of Service)

Respite Care Service: \_\_\_\_\_  
(Name of Service)

Doctor / Medical Professional: \_\_\_\_\_  
(Name of Professional)

DoCS Case Worker: \_\_\_\_\_

Other Service Providers as Specified:  
\_\_\_\_\_  
\_\_\_\_\_

CENTRELINK: YES [ ] NO [ ]

RE: \_\_\_\_\_  
(Name of Service User)

**Please specify if there is any information you do not wish to be released:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you wish to be notified before any specific information is given to anyone else?  
YES [ ] NO [ ]

\_\_\_\_\_  
SIGNATURE RELATIONSHIP DATE

\_\_\_\_\_  
WITNESS DATE