Hearing Services Program Client Relocation Consent Form

**New Service Provider Name**

**Client Full Name Voucher Number**

**Power of Attorney/Guardianship/Equivalent arrangement in place Yes No**

**Full name of Client/Power of Attorney/Guardian/Equivalent**

**Verbal consent given by the client or Power of Attorney/Guardian/Equivalent**

**Verbal consent date**

If verbal consent is given, the client/POA/guardian/equivalent must still give written consent by signing and dating this form at their first visit. The information listed below must be provided when verbal consent is being obtained.

## Client/POA/Guardian/Equivalent Certification

* I wish to relocate and obtain futurehearing services from the above provider. I consent to the transfer of my client file from my current hearing services provider to this provider.
* I acknowledge that if I do not wish to be contacted by my previous provider or do not want my previous provider to use my information, I will need to phone or write to my previous provider.
* Provider may wish to insert their privacy consent information here (refer Australian Privacy Principles requirements)

**Name (please print) Signature Date**

The completed form must be kept on the client record.

**CRC0320**