Insert Provider Logo Here

A Provider Name
A Provider Address
A Provider Contact Number

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 future hearing 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.

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