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Australian Government
Department of Health and Aged Care

Hearing Services Program

Hearing Services Program – Client Relocation Consent

This form is for Hearing Services Program clients wanting to transfer to a new service provider.

Client full name

New service provider name

Power of attorney/guardianship/equivalent arrangement in place

Yes ☐ No ☐

If 'Yes', full name of power of attorney/guardian/equivalent

Contact number

Client/POA/Guardian/Equivalent Certification

I certify that:

- I wish to relocate and obtain future hearing services from the above provider.
- I consent to the transfer of my complete client file from my current hearing services provider to the above provider.
- 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.

Name (please print)

Signature

Date DD / MM / YYYY

Provider use

Voucher number

Verbal consent given by the client ☐ or Power of attorney/guardian/equivalent ☐

Verbal consent date DD / MM / YYYY

Note: Verbal consent can be obtained to relocate in the portal but written consent or audio recording is required before services can be provided. Full details in Schedule of Service Items and Fees.

The completed form must be kept on the client record.