**Third Party Authority to**

**Exchange Information**

For further information contact 0450983223 or admin@nextstepinitiative.com.au

|  |
| --- |
| **Participant Details** |

|  |  |
| --- | --- |
| Name |  |
| DOB |  |
| NDIS # |  |
| Contact number |  |
| Email Address |  |
| Address |  |

Where applicable please complete the following section to have a nominated alternative contact this may be representative, advocacy member, parent/guardian or support person.

**Nominated Alternative contact details**

|  |  |
| --- | --- |
| Name |  |
| DOB |  |
| Relationship to Participant |  |
| Contact number |  |
| Email Address |  |
| Address (if different to participant) |  |

To provide the best possible service, NextStep Initiative Pty Ltd May require sharing, retain collect, exchange and communicate with other providers involved with your care needs

Information to be shared and collected:

|  |  |
| --- | --- |
| * SA Health
 | * GP Clinics
 |
| * Hospitals
 | * Community Mental Health Agencies
 |
| * Specialists
 | * Corrections
 |
| * Department of Education
 |  |

|  |
| --- |
| **Information to be shared**  |
| **Provider** | **Location** | **Purpose of information** |
|  |  | Information relation to management of disability/condition and communicating with providers and supports |
|  |  |  |
|  |  |  |
|  |  |  |

**Record of consents:**

NextStep Initiative Pty Ltd have discussed why and how certain information will be collected, retained and shared with other service providers.

I understand this and by signing I acknowledge the following:

* NSI will collect and retain information for the prescribed period for 7 years or until 25 for persons under 18
* NSI will share and will share and exchange information between the above-mentioned providers.
* By sighing this form, I am also providing authority for NSI to contact my support staff, if deemed necessary.
* The information provided to NSI on this authorisation, and that which can be obtained by using this authority to exchange personal information, will only be used in relation to the management of the disability/ condition and communicating with providers and supports.
* I have given this authority freely and with no limitation (unless otherwise indicated)

**Record of consent**

|  |  |
| --- | --- |
| **Participant/ Representative Name**  |  |
| **Signature** |  |
| **Date** |  |

The authority remains valid with NextStep Initiative for the duration of services, unless it is suspended by a new authority or until such time myself or my representative withdraw or revoke the authority. A review of current will be undertaken at the start of each plan date.