

Client Consent to Obtain & Release Information Form

Note: This form can only be completed by the Client or the Authorised Representative

Privacy Policy:

I hereby acknowledge that My Plan Manager.com.au Pty Ltd ACN 617 963 676 (**My Plan Manager**) has provided me with access to My Plan Manager' Privacy Policy which sets out.

- my right to access personal information.
- my right to withdraw my consent at any time; and
- what personal information will be collected and disclosed and why.

Part 1: NDIS Participant Details

| | |
|---------------------------|--|
| Full Name of Participant: | |
| NDIS Number: | |
| Participant Address: | |
| Date of Birth: | |

Part 2: Authorised Representative (if client is not primary decision maker)

PLEASE NOTE: Only complete this section if the Participant is not the primary decision-maker. Authorised Representative must be a person recognised by the NDIA as a substitute decision maker or nominee. Authorised Representative is automatically granted full access to the MPM On-line Portal.

| | | | |
|---|---|---|--|
| Full Name of Authorised Representative: | | | |
| Relationship of Authorised Representative with Participant: (e.g., mother, father) | | | |
| An immediate parent/guardian <input type="checkbox"/> | A person appointed by the NDIA as a Plan Nominee <input type="checkbox"/> | Third Party legally appointed Guardian <input type="checkbox"/> | |
| Contact Number: | | | |
| Email Address: | | | |
| Address of Authorised Representative: | | | |

Part 2a: Alternative Contact Person (if applicable)

| | | | |
|--|------------------------------|-----------------------------|---------|
| Full Name: | First Name | Middle Name | Surname |
| Contact Number: | | | |
| Email Address: | | | |
| Relationship with client: | | | |
| Allow Access to MPM On-line Portal ("read only") | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |

Part 3: Service Providers

Please provide details of Service Providers with whom My Plan Manager can share information for the purposes of providing plan management services under the Service Agreement with the Participant/Authorised Representative.

☐ No Service Providers ☐ All Service Providers ☐ Only the following Service Providers:

Part 4: Support Co-Ordinator or Recovery Coach (if applicable)

Please provide details of Support Co-Ordinator / Recovery Coach business with whom My Plan Manager can share information for the purposes of providing plan management services under the Service Agreement with the Participant/Authorised Representative.

Where providing consent to share for a whole Support Coordination company rather than an individual, please list the business email address, phone number, business name, and elect whether portal access is to be granted for the company.

| | | | |
|---|--|--|--|
| Business Name: | | | |
| Contact Person 1: | | | |
| Support Co-Ordination or Recovery Coach: | Support Co-ordination <input type="checkbox"/> | Recovery Coach <input type="checkbox"/> | |
| Contact Person 1 Email Address: | | | |
| Business Contact Email: <small>(for circumstances in which permission is provided to share information with the business when the main contact is not available or there is no main contact person)</small> | | | |
| Telephone: | | | |
| I consent to Support Co-Ordinator/Recovery Coach having "READ ONLY" access to my MPM On-line Portal/App. Yes <input type="checkbox"/> No <input type="checkbox"/> | | I consent to the Support Co-Ordinator/Recovery Coach <u>Company/Business</u> having "READ ONLY" access to my MPM On-line Portal/App. Yes <input type="checkbox"/> No <input type="checkbox"/> | |

| | | |
|--|--|---|
| Business Name: | | |
| Contact Person 2: | | |
| Support Co-Ordination or Recovery Coach: | Support Co-ordination <input type="checkbox"/> | Recovery Coach <input type="checkbox"/> |
| Contact Person 2 Email Address: | | |
| Business Contact Email: (for circumstances in which permission is provided to share information with the business when the main contact is not available or there is no main contact person) | | |
| Business Telephone: | | |
| I consent to Support Co-Ordinator/Recovery Coach having "READ ONLY" access to my MPM On-line Portal/App. Yes <input type="checkbox"/> No <input type="checkbox"/> | I consent to the Support Co-Ordinator/Recovery Coach <u>Company/Business</u> having "READ ONLY" access to my MPM On-line Portal/App. Yes <input type="checkbox"/> No <input type="checkbox"/> | |

Part 5: Audit Purposes

I am aware that I am automatically enrolled in audit processes and may be contacted by the audit team of My Plan Manager for interviews and/or have files reviewed to ensure that My Plan Manager complies with the NDIS Practice Standards. I am aware that if I do not want to participate in this audit process, My Plan Manager will document and respect that decision.

Please tick if you **do not wish** to be a part of the audit process-

Tick Box: ☐

Part 6: Signature

I declare the information I have provided in this document is true and accurate to the best of my knowledge. I have not deliberately provided any false or misleading information. I understand that I may revoke this consent at any time, by sending written notification to My Plan Manager at enquiries@myplanmanager.com.au

| | |
|------------------|--|
| Print Full Name: | |
| Signature: | |
| Date: | |

Please note: SIGNATURE OF PERSON COMPLETING FORM (MUST be either the NDIS Participant or an Authorised Representative who is recognised by the NDIA as the plan nominee)