### Authority to Act as an Advocate

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| **Client Details** | | | |
| Name: | | | |
| Date of birth: | | Email: | |
| Address: | | | |
| Home phone: | Mobile phone: | | Work phone: |

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| Advocate / Support / Nominated Person | |
| Please enter the details of the person you’d like to give authority to act on your behalf. | |
| Full name: | Relationship to you: |
| Postal address: | |
| Email address (if applicable): | Home phone: |
| Mobile phone: | Work phone: |

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| **Authority to Act** | |
| Effective from: |  |
| I authorise the provider to act on the instructions of my nominated person  I understand that provider is not responsible for any actions of my nominated person using this authority  I understand that this authority comes into effect from the date above or from when form is received whichever is the later.  I understand that I am giving my nominated person authority to access my information by telephone, email and letter  I understand I can write to or call the provider at any time to cancel this authority, and the provider will only cancel this authority if I ask them to in this way. Cancellation will not be effective until received by the provider | |

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| Participant’s Approval | |
| Signature: | Date: |

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