MID NORTH COAST

THERAPY AND SUPPORTS

Authority to Act and Consent to Release Information

I, _____ (Full name),

hereby authorise **Sharon Denham, Accredited Social Worker (AASW)** of **Mid North Coast Therapy and Supports**, to act on my behalf (or on behalf of my child:

_____, DOB: _____ / _____ / _____), in matters relating to the collection and sharing of personal, medical, educational, psychological and other relevant information for the purposes of assessing and supporting a diagnosis of **Fetal Alcohol Spectrum Disorder (FASD)**.

This authorisation includes, but is not limited to, communication with and the request and receipt of information from:

- Medical professionals (e.g., general practitioners, paediatricians, allied health professionals)
- Educational institutions and school staff
- Government departments and agencies (e.g., NDIS, DCJ, Centrelink)
- Non-government organisations or support services
- Any other party relevant to the FASD diagnostic process

I understand that this information will be used solely for the purpose of supporting a FASD assessment and diagnosis, and will be handled in accordance with relevant privacy legislation and professional ethical standards.

This authority remains in effect until:
☐ Completion of the diagnostic process
☐ 12 months from the date of signing
☐ Other: _____

I understand that I may revoke this authority at any time in writing.

Signature of Client/Parent/Guardian: _____

Name: _____

Date: _____ / _____ / _____