

Consent To Obtain and Release Information Form

As an active participant of the NDIA you have selected, Home Nursing Solutions (HNS) as your;

Support Coordinator;
Plan Manager; or
Service Provider

Home Nursing Solutions may be required to discuss information relating to your medical conditions, medication, allergies, and / or any other relevant matters as required with the following people and organisations:

1. NDIA
2. Therapists
3. Health Workers
4. Consulting Physician
5. Emergency contact / Next of Kin
6. Paramedics
7. Schools
8. Other related parties (e.g social worker)

If Home Nursing Solutions need to seek information relating to your NDIA Plan, then we note that your authority is provided in this form for;

Home Nursing Solutions P./L of;
271 The Parade, Beulah Park, SA, 5067
ABN 83 610 592 777
NDIA Registration Number; 4050006465

Along with the following officers;

- | | | |
|---------------------|-----------------------------|------------------------|
| 1. Director | Home Nursing Solutions P/L; | Mrs. Kate Kelly |
| 2. Care Coordinator | Home Nursing Solutions P/L; | Mrs. Carli Funk Tiwari |
| 3. Finance Manager | Home Nursing Solutions P/L; | Miss Sarah Lam |

Home Nursing Solutions and the officers listed above to speak with the NDIA and its officers to seek answers to questions and gather information that is relevant to the services provided to you or the person you care for by Home Nursing Solutions.

By signing this form, you consent to HNS discussing and disclosing these details with those listed above. Where possible, HNS will speak with you first about their intended communications.

PLEASE COMPLETE ONE OF THE FOLLOWING



I hereby authorise HNS to discuss and disclose any information about my medical conditions, medication, allergies, and / or any other relevant matters as required with the people and organisations stated above.

_____ [Sign] _____ [Date]

I , guardian / carer of

hereby give consent for Home Nursing Solutions to discuss and disclose NDIA plans, information relevant to the NDIA plans and information relating to their medical conditions, medication, allergies, and / or any other relevant matters as required with the people and organisations stated above.

_____ [Sign] _____ [Date]

By signing this form, you consent to HNS discussing and obtaining this information and discussing your plan with the NDIA. Where possible, HNS will speak with you first about their intended communications.