MEDICAL INFORMATION CONSENT FORM

Your NDIS Service Provider

ABN: XX XXX XXX XXX

Date: 19/09/2025

PARTICIPANT INFORMATION

Name:	Emanuel Singh
Date of Birth:	03/09/2025
NDIS Number:	

CONSENT FOR MEDICAL INFORMATION

I, Emanuel Singh, give my consent for Your NDIS Service Provider to:

☐ Access my medical information relevant to the provision of support services

☐ Communicate with my healthcare providers regarding my care and support needs

☐ Share my medical information with relevant support workers involved in my care

☐ Store my medical information securely in accordance with privacy laws

☐ Act on my behalf in medical emergencies when I cannot provide consent

HEALTHCARE PROVIDERS

I authorize Your NDIS Service Provider to communicate with the following healthcare providers:

Provider Type	Name	Phone
General Practitioner	_____	_____
Specialist	_____	_____
Allied Health Professional	_____	_____
Pharmacy	_____	_____

LIMITATIONS AND CONDITIONS

- This consent applies only to medical information necessary for the provision of NDIS support services
- Medical information will be shared only with authorized support workers directly involved in my care
- All medical information will be stored securely and in accordance with privacy laws
- I can withdraw this consent at any time by providing written notice
- This consent remains valid until withdrawn or until my services with Your NDIS Service Provider end

Participant/Representative Signature Witness Signature

Emanuel Singh

Date: _____

Your NDIS Service Provider Representative

Date: _____