Desert Therapy
ABN 59 630 016 330

AUTHORISTION TO RELEASE AND CONSENT TO EXCHANGE INFORMATION

This consent form relates to personal information about:

(Name) ________________________________(D.O.B) ______________________,

of (Address) ____

I, (Name) ______________________________________, GIVE CONSENT for Desert Therapy to seek and disclose relevant health information to inform best practice from the following organisations:

- ☐ Alice Springs Hospital
- ☐ Central Australian Health Service i.e., CDT/AAHT
- ☐ Royal Adelaide Hospital
- ☐ Tennant Creek Hospital
- ☐ Australian Hearing
- ☐ Congress
  - ☐ Alice Springs
  - ☐ Tennant Creek
- ☐ NDIS/NDIA
- ☐ NT Hearing

Other:____

I further give consent for Desert Therapy to collect, use and retain my information and that it is kept for no longer than is necessary and is disposed of securely. My information is protected against loss, unauthorised access, modification or disclosure and against all other misuse.

MULTIMEDIA CONSENT

I give consent for photographs, voice recordings and video recordings to be taken of me for the purpose of assisting with clinical decisions that relate to my care, with every effort to keep identifying features private.

Clinical Decisions ☐ Yes ☐ No

I give consent for photographs and video recordings to be taken of me for social media.

Desert Therapy Facebook Page Yes ☐ No ☐

Desert Therapy Website Yes ☐ No ☐

(Signature)_____________________________ (Date) ________________________________

4/1 Colson Street,
Alice Springs NT 0870

PO Box 4274,
Alice Springs NT 0871

Phone: 08 8960 5905

admin@deserttherapy.com.au

www.deserttherapy.com.au