Consent to Exchange Information

Please read this information, then complete the authorisation pages that follow.

ABOUT US

Rayze Pty Ltd is a multidisciplinary allied health service provider. Our professionals work across a range of disciplines to provide coordinated, comprehensive care that addresses your individual needs.

Our team may include psychologists, speech pathologists, occupational therapists, educators, dietitians and therapy assistants. In this document, these professionals are collectively referred to as clinicians.

To support your care and treatment, your clinicians may need to share relevant information with one another. If you do not want your information shared with other clinicians at Rayze, please tell your clinician directly.

With your consent, we may share your information with service providers outside Rayze, including your doctor, employer, education provider and other treating professionals.

For further information on our Policies and Codes of Conduct, please visit www.supersaurus.com.au/rayze.

PRIVACY POLICY

We respect your privacy and will only share your information when necessary. We may share information without your consent where required by law or where necessary to keep you or another person safe. To authorise us to exchange your information, please complete the authorisation pages that follow.

PERSONAL INFORMATION

As part of providing services to you, we need to collect and record personal information relevant to your situation, such as your name, contact details, medical history and other relevant information. Collecting this information is a necessary part of assessment and treatment.

PURPOSE OF COLLECTING AND HOLDING INFORMATION

We collect your personal information as part of your assessment and treatment. It is stored securely and, to protect your privacy, is accessed only by your clinician and authorised Rayze staff when needed. We keep this information to record what happens in your sessions and to help your clinician provide care that is relevant to you.

CONFIDENTIALITY

All personal information gathered while we provide your services is kept confidential and secure. We will only share it if a court subpoenas it, if keeping it private would place you or someone else at serious and imminent risk, or if the law otherwise requires or allows it. We will also share it when you have given us permission, for example to send a written report to another professional or agency, or to discuss your care with someone such as your Co-ordinator of Supports.

Consent to Exchange Information

CLIENT DETAILS

First Name		**Surname**	
Date of Birth		**Preferred Name**	
Gender	Male	**Preferred Pronouns**	He/Him
Mobile Number		**Email Address**	
Home Address			

REPRESENTATIVE DETAILS

If applicable. For example a guardian, nominee, or a person who supports you with decisions

First Name		**Surname**	
Relationship	Mother	**Mobile Number**	
Email Address			
This person is my legal representative (e.g. guardian or power of attorney)	☐ Yes ☐ No		

I have read and understood the Consent to Exchange Information guide and agree that Rayze Pty Ltd can exchange information with the following parties:

EMPLOYER

If not employed, please write NA

Employer Name		**Position**	
Email		**Phone Number**	

EDUCATION PROVIDER

For example university or TAFE. If not studying, please write NA

Provider Name		**Contact Person**	
Email		**Phone Number**	

FAMILY MEMBER OR SUPPORT PERSON 1

For example a partner, parent, sibling or friend

Name		**Relationship**	
Email		**Phone Number**	

FAMILY MEMBER OR SUPPORT PERSON 2

For example a partner, parent, sibling or friend

Name		**Relationship**	
Email		**Phone Number**	

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I have read and understood the Consent to Exchange Information guide and agree that Rayze Pty Ltd can exchange information with the following parties:

NDIS

If applicable

NDIS Number		**LAC**	
Plan Manager		**Email Address**	

CO-ORDINATOR OF SUPPORTS

If applicable

Full Name		**Company**	
Phone		**Email Address**	

SUPPORT WORKER

If applicable

Full Name		**Mobile**	
Email Address			

GENERAL PRACTITIONER (GP)

Full Name		**Practice**	
Phone		**Email Address**	

SPECIALIST DOCTOR

For example Psychiatrist, Neurologist

Full Name		**Practice**	
Type		**Email Address**	

OTHER THERAPISTS

For example OT, Psychologist, Speech Pathologist. If you need more room, please attach a separate page and sign it.

Full Name	Practice	Type	Phone	Email Address

SIGNATURE

Client, or guardian or legal representative

Name		**Signature**	
Date		**Relationship (if not the client)**	Mother