



Consent To Share Information

Financial Plan Management Services

Only you (LEISURE NETWORKS client), your Guardian or Authorised Representative may give consent to share. The information we share can include your current budget amounts, information about recent invoices and providers you have engaged, client details and representative contact details. You can tell us what you want to share.

Giving additional parties consent to access your personal information is purely optional and will not affect our services. You have the ability to add or remove people to your Consent to Share list in the future.

FULL NAME	
NDIS NUMBER	

I, _____
(the client or the name of the guardian or authorised representative to act on behalf of the client),
hereby consent to Leisure Networks sharing information about my/the NDIS plan with the following
parties:

SECONDARY CONTACT

(EG: YOUR PARENT, A CO-PARENT/GUARDIANS, GRANDPARENTS, CLOSE FRIENDS ETC)

FULL NAME	
PHONE	
EMAIL	
ADDRESS	
RELATIONSHIP TO PARTICIPANT	

I am the Primary Contact for this Participant (please select only 1 Primary Contact)

Please tick relevant information to share:

- | | |
|--|--|
| <input type="checkbox"/> ATS - Client Name & NDIS Number | <input type="checkbox"/> Statement Recipient |
| <input type="checkbox"/> ATS - Recipient (statement, balances, spending & dates) | <input type="checkbox"/> ATS - Confirmation of services provided |
| <input type="checkbox"/> Access to Leisure Networks Portal | |

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SUPPORT COORDINATOR (IF APPLICABLE)

FIRST NAME	
LAST NAME	
PHONE NUMBER	
EMAIL ADDRESS	
COMPANY	

- I am the Primary Contact for this Participant *(please select only 1 Primary Contact)*
- Consent extends to other Support Coordinators in the organisation

Please tick relevant information to share:

- ATS - Client Name & NDIS Number
- Statement Recipient
- ATS - Recipient (statement, balances, spending & dates)
- ATS - Confirmation of services provided

ADDITIONAL CONTACT

(EG: YOUR PARENT, A CO-PARENT/GUARDIANS, GRANDPARENTS, CLOSE FRIENDS ETC)

FIRST NAME	
LAST NAME	
PHONE NUMBER	
EMAIL ADDRESS	
RELATIONSHIP TO PARTICIPANT	

Please tick relevant information to share:

- ATS - Client Name & NDIS Number
- Statement Recipient
- ATS - Recipient (statement, balances, spending & dates)
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AUTHORITY AND DECLARATION

I declare that I have the authority to approve this consent to share form in the following capacity as:

The client

A parent of the client who is under 18 Y/o

A guardian / authorized representative of the client.

Client /guardian/ authorized
representative full name

Signature

Date: _____

You may revoke these permissions at any time by: Emailing
fpmenquiry@leisurenetworks.org