AUTHORITY TO ACT FORM

I, {INSERT NAME}, authorise {INSERT NAME OF AUTHORISED PERSON} to act on my behalf in relation to the Information Access Request I have made to Sunshine Coast Health Network (SCHN).

I understand that officers of Sunshine Coast Health Network will deal directly with {INSERT NAME OF AUTHORISED PERSON} in relation to this complaint.

I authorise {INSERT NAME OF AUTHORISED PERSON} to:

Receive my personal information and related documents from Sunshine Coast Health Network.

Discuss my request with relevant staff of Sunshine Coast Health Network.

I understand that I can withdraw my authority to act at any time by contacting the Sunshine Coast Health Network.

I understand that Sunshine Coast Health Network will use and store my personal information in accordance with the Privacy Act 1988 (Cth).

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: {Insert Name}

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_