SYNERGY WEST
PLAN MANAGEMENT

SYNERGYWEST INFORMATION SHARING CONSENT FORM

This form must be completed by either the Client or their Authorized Representative.

Purpose:
The purpose of this form is to obtain your consent to share personal and sensitive information between SynergyWest and third parties involved in your support services. By granting consent, you are allowing us to share the necessary information to provide you with high-quality services and to ensure seamless coordination among relevant parties.

Privacy Notice:
I confirm that SynergyWest has made its Privacy Policy available to me. This policy details:

- My right to access my personal information.
- My right to revoke consent at any time.
- The types of personal information that will be collected, shared, and the reasons for such sharing.

Part 1: NDIS Participant Details

Full Name of Participant:	
NDIS Number:	
Participant's Address:	

Part 2: Authorized Representative (if client is not the primary decision maker)

NOTE:
This section should only be filled out if the Participant is not the primary decision-maker. The Authorized Representative must be someone acknowledged by the NDIA as a substitute decision maker or nominee. The Authorized Representative will be granted full access to the SynergyWest Online Portal.

Full Name of Authorized Representative:	
Relationship to Participant:	
Contact Number:	
Email:	
Address of Authorized Representative:	

Alternative Contact Person (if applicable)

Full Name	
Contact Number	
Email Address	
Relationship with client:	
Allow Access to SynergyWest Portal? YES ◯ NO ◯	

Part 3: Service Providers

Kindly provide the names of the Service Providers with whom SynergyWest can share information in order to deliver plan management services as per the Service Agreement.

Allow access to only the following Service Providers:	
Consent to share Information with all service providers: YES ◯ NO ◯	
Consent to share Information with no service providers: YES ◯ NO ◯	

Part 4: Coordinator or Recovery Coach (if applicable)

Please provide the contact information of the Support Coordinator/Recovery Coach with whom SynergyWest may share information to facilitate plan management services under the Service Agreement.

Business Name	
Contact Number (Primary)	
Contact Number (Other)	
Email (Primary)	
Email (Other)	
Business Email (when main contacts are not available)	
Support Coordination or Recovery Coach:	Support Coordinator ☐ Recovery Coach ☐
Allow Access to SynergyWest Portal?: YES ◯ NO ◯	

Part 5: Audit Purposes

I understand that I am automatically included in the audit process and may be contacted by the SynergyWest audit team for interviews or file reviews to ensure adherence to NDIS Practice Standards. If I choose not to participate in the audit, I can formally document and notify SynergyWest of my decision

☐ Please check this box if you prefer not to participate in the audit process.

Part 6: Signature

I confirm that the information provided in this document is correct and complete to the best of my knowledge. I have not intentionally given any false or misleading details. I understand that I can withdraw my consent at any time by submitting written notice to SynergyWest at info@synergywest.com.au.

Full Name:

Signature of Participant or Guardian /Authorised representative

Date: