



**THE EPILEPSY CENTRE OF SA & NT  
CLIENT CONSENT FORM**

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Client Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Postcode: \_\_\_\_\_

Phone No: \_\_\_\_\_

Email address: \_\_\_\_\_

I am an NDIS Client: Yes [ ] No [ ]

My NDIS number is: \_\_\_\_\_

I understand The Epilepsy Centre of SA & NT requires my informed, signed consent to share information with others.

I authorise The Epilepsy Centre of SA & NT Inc, to contact my Doctors, Neurologist, any other Specialist, relevant government departments and NGOs to discuss any issues that may arise with regard to my epilepsy. I recognise The Epilepsy Centre of SA & NT is obliged to collect, store and report information, and I consent for this to occur in accordance with The Epilepsy Centre of SA & NT Privacy Policy.

View our Privacy Policy at [www.epilepsycentre.org.au](http://www.epilepsycentre.org.au)

I understand that I may revoke this Consent at any time by sending written notification to The Epilepsy Centre of SA & NT.

This authorisation is valid from this date: Day: \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

Full Name: \_\_\_\_\_

Signature: \_\_\_\_\_

EASANT Full Name: \_\_\_\_\_

EASANT Signature: \_\_\_\_\_