Authority to Act as a Client Advocate

cohealth
care for all

Client Details

First name:

Last name:

Address:

Telephone:

Mobile number:

Email address:

I authorise the person named on this form, to act as an advocate on my behalf and represent my interests in relation to my involvement with cohealth.

I understand that cohealth may discuss details of my care with my advocate if the need arises.

This authority takes effect from ____/____/____ and replaces any previously advised arrangements. I understand that I can change my choice of advocate at any time and will advise cohealth of this change in writing.

This form is valid for 12 months and will need to be completed annually to remain valid.

Client Signature:

Date:

Client Advocate's Details

Advocate's first name and last name:

Advocate's address:

Mobile number:

As an advocate of
I will ensure that:

- ☐ the client has provided written authority for me to act as their advocate.
- ☐ I always act in the best interests of the client.
- ☐ the client is aware of any issues and developments in relation to the support they receive and which as their advocate, I may be involved.
- ☐ I am familiar with the client's Support Plan and fees schedule (if applicable).
- ☐ I am familiar with the client's 'Rights and Responsibilities'.
- ☐ I advise cohealth of changes in the client's circumstances and any concerns about their changing needs.
- ☐ I am prepared to relinquish the role of advocate should the client request this.

Signature of Authorised Client Advocate:

Date:

Further information

Please return the completed form to reception at any cohealth site. Further information regarding Advocates is available at www.cohealth.org.au/client-advocate. If you have any further queries, please contact the Privacy Officer by email to privacy@cohealth.org.au or by phone on (03) 9448 6102

Internal use

Date received:	EHR's uploaded to:
Received by staff member:	Upload date: