



DACSSA
DISABILITY ADVOCACY

CONSENT FORM

To Disability Advocacy and Complaints Service SA ('DACSSA')

Please complete all fields.

I, (full legal name)

of (address)

Give (name of consented person) consent to (tick):

- Speak on my behalf to DACSSA
- Act on my behalf to communicate with DACSSA
- Share information about my disability to DACSSA
- Share information about my life to DACSSA
- Make some decisions with me about advocacy

DECLARATION

I declare that I understand DACSSA's Privacy Policy. I have been honest about who I am and I am aware of my rights and responsibilities when declaring consent

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Signed (person wanting DACSSA's assistance)

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Date