OstaraAustralia
RECRUITMENT. TRANSFORMING LIVES

Permission to Disclose and Verify Information

I, ________________________________ (print client's name) give my permission to Ostara Australia at ________________________________ (site name) to disclose and verify:

(Please tick the appropriate permissions):

☐ **Limited Disclosure** to potential and current employers of my involvement in Disability Employment Services enabling Ostara Australia to offer employer incentives and receive payslips summaries from the employer without disclosing my particular health/disability issues, and to contact my medical practitioner to enable better support during my period of service.

☐ **Full Disclose** as necessary, of my health/disability related issues to a potential/current/future Employers, Educational Institutes, Training Organisations and my medical practitioner for the purposes of: securing sustainable employment & assist the employer to have a greater understanding of implementing work processes/systems to effectively minimise any health/disability related issues; assist the educational institutes develop a tailored teaching plan, where necessary; & providing the training organisation with information to suffice a reduction in the module loading which allows for training to be conducted over a longer timeframe. This allows Ostara Australia to offer employer incentives and receive payslips summaries from the employer.

☐ **Specific Disclosure** - Please indicate any specific instructions on what Ostara Australia is able to present to the Employers, Educational Institutes, & Training Organisations, how would you like your health/disability presented to the Employer, Educational Institute, Training Organisations and medical practitioners:

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☐ **Verifying Information –** To contact potential, current and future employers, education institutions and my medical practitioner for the purpose to assist me with gaining employment and to confirm any current or future employment (including hours worked and pay rate) and educational institutions (Confirming details of education activities, semester dates, completion of semesters and satisfactory attendance)

☐ I give my consent for the above for entire length of my participation in the DES program

OR

☐ I give my consent between these dates ___/___/___ to ___/___/___ (maximum 12 months)

I understand that this information will be handled in accordance with the Privacy Act 1988 and that details may be verified with Or provided to other agencies including Centrelink to ensure I receive correct entitlements and to the Department of Social Services for monitoring and evaluation purposes. I also confirm that I have been handed information on the Privacy Policy for the Ostara Australia service at and I can withdraw my consent at any time.

Client Signature:	________________________________	Date: ___/___/___
Consultant Name:	________________________________	
Consultant Signature:	________________________________	Date: ___/___/___