

# Westfund Privacy Consent to Disclose Information

Member

Membership Number: \_\_\_\_\_

Member's Full Name: \_\_\_\_\_  
First / Middle / Surname

Member's Address: \_\_\_\_\_ P/Code: \_\_\_\_\_

## Authorise

Third Party

Third Party Full Name: \_\_\_\_\_  
First / Middle / Surname

Third Party's Address: \_\_\_\_\_ P/Code: \_\_\_\_\_

## Declaration

I authorise the above person to act on my behalf and have access to my membership details. This includes health information about me and my dependants that are under 15 years of age which appear on my membership.

I understand that this form and the information it contains may be used by Westfund to manage the personal information that it holds about me.

I know that I can gain access to my information and understand that my information may be disclosed to the person I have authorised to act on my behalf.

I understand that I can withdraw my consent at any time by notifying Westfund in writing of my intention.

## Signature of Member

Member's Full Name (Print): \_\_\_\_\_

Signature: ..... Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Day Month Year

## Witness

Witness's Full Name (Print): \_\_\_\_\_

Signature: ..... Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Day Month Year

## Office Use Only

Verified by: \_\_\_\_\_

Signature: ..... Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Day Month Year



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