



ADVOCATE AUTHORITY FORM

I _____ DOB _____
(Client's name)
Of _____
(Client's Address)

GIVE AUTHORITY TO:

(Name of person authorised)
Of _____
(Name of support organisation: if appropriate)
Postal Address _____

NSW _____
Email: _____
Phone: _____ FAX: _____ Mobile: _____

For how long do you want this authority to last? (Select one only)

- 6 months
 From _____ to _____

I know that I can change my mind and stop my consent at any time by writing or telling the Housing Appeals Committee unless there is a current legal order in place.

TO (cross out any that are not applicable)

- Talk with the HAC staff and Committee regarding my appeal for housing assistance
- Advocate on my behalf
- Receive copies of all correspondence from HAC
- View and handle personal information and information from publically available sources about me (as obtained by HAC) including information from my tenancy file as well as other personal / health information as obtained from authorised third parties

Signed: _____ Date: _____
(Client's signature)

Please return this form to

Fax: (02) 8741 2566 Email: hac@facns.nsw.gov.au