Department of Social Protection - Treatment Benefit Consent Form

Name: _____ PPSN: _____ DOB: _____

I the undersigned, authorise _____ Hair Replacement provider to use my personal data for the purposes of checking my eligibility for Treatment Benefits and to allow for the processing of the payment claim in respect of treatments I have received.

I understand that I may revoke this consent at any time by contacting the Department.

Signature of patient: _____

Signature on behalf of the provider: _____

Date: _____

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Signature of Customer: _____

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Date: _____