KELLSARR FAMILY PRACTICE

Authority to Communicate Form

Clarity • Dignity • Practical Support

Client Details

Full Name: _____
Address: _____
Telephone: _____
Email: _____

Authority

I authorise Kellsarr Family Practice to communicate on my behalf where appropriate.

Organisations:

☐ Schools
☐ Local Authority
☐ Social Services
☐ HMCTS (administrative matters only)
☐ Cafcass
☐ Solicitors
☐ Other: _____

Purpose

This authority is limited to obtaining or providing information necessary to assist me. I understand Kellsarr Family Practice does not undertake reserved legal activities or regulated legal representation.

Duration

This authority remains in force until my matter concludes or until I withdraw consent in writing.

Declaration

I confirm I give my informed consent for Kellsarr Family Practice to communicate with the organisations selected above.

Signatures

Client Signature: _____ Date: _____

Representative: _____ Date: _____

This document forms part of the Kellsarr Family Practice Client Resource Pack.