

**AUTHORITY TO RELEASE INFORMATION
TO WHOM IT MAY CONCERN**

I, Date of Birth:/...../.....
of

Authorize Leishman Financial Services Pty Ltd to have access to our/my investment and financial details. I request that all relevant information on our/my investments, insurances, superannuation, bank accounts or other financial information be released to Leishman Financial Services staff, this is to include statements or other documents that may be requested by Leishman Financial Services. Leishman Financial Services Pty Ltd is an Australian Financial Services Licensee, Number 227747.

Leishman Financial Services Pty Ltd
4/295 Springvale Road, Glen Waverley Vic 3150
PO Box 3
Glen Waverley Vic 3150
Ph: (03) 9561 9699
Fax: (03) 9561 9301

The Financial Planner providing me with advice is.....

I instruct you to accept a photocopy or facsimile copy of this letter as authority, as the original will stay on file at Leishman Financial Services Pty Ltd.

Signed: _____ (Client) Signed: _____
(Adviser)
Date: ___/___/___ Date: ___/___/___

Policies / Accounts to which the above authority extends:

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