



**Embassy of The State of Kuwait  
Canberra**

This form enables you to:

- Request consular assistance from (Kuwait)
- Consent to Australia officials disclosing your personal information for the purpose of obtaining consular assistance for you
- Consent to your personal contacts being informed of your situation

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

NATIONALITY: \_\_\_\_\_

PASSPORT NUMBER: \_\_\_\_\_

**1. CONSULAR CONTACT / ACCESS**

**Please  
tick**

**Consent**

I want to be contacted/ visited by consular officials from (Kuwait)

I understand that this consent is valid unless I withdraw it

**OR**

**Do not consent**

I do not want to be contacted/ visited by consular officials from (Kuwait)

**2. CONSENT TO THE DISCLOSURE OF PERSONAL INFORMATION TO  
CONSULAR OFFICIALS**

**Consent**

I consent to Australian officials continuing to disclose personal information about me (including but not limited to the details provided above) to consular officials of (Kuwait) to enable them to provide me with consular assistance

I understand that this consent is valid unless I withdraw it

**OR**

**Do not consent**

I do not consent to Australian officials continuing to disclose personal information about me to consular officials of (Kuwait)

**3. CONSENT TO THE DISCLOSURE OF PERSONAL INFORMATION TO PERSONAL CONTACTS**

**Consent**

I consent to officials of (Kuwait) disclosing personal information about me (including but not limited to the details provided above and information about my situation) to the following (e.g.: next of kin, friend, lawyer, doctor):

I understand that this consent is valid unless I withdraw it

A. \_\_\_\_\_  
\_\_\_\_\_  
(Insert name, address and contact phone or email if known)

B. \_\_\_\_\_  
\_\_\_\_\_  
(Insert name, address and contact phone or email if known)

C. \_\_\_\_\_  
\_\_\_\_\_  
(Insert name, address and contact phone or email if known)

I do not consent to the following types of personal information being disclosed to the persons listed at A, B or C above (e.g.: police or medical records, or whereabouts)

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name and signature of witness