Informed Consent Form

Name: _____	Date of Birth : _____
Address: _____	Phone: _____

Please indicate if you have received and understood the following information. If you have trouble understanding this information please ask staff to help.

- ❑ Program Information Sheet
- ❑ Rights and Responsibilities Statement
- ❑ Privacy Statement
- ❑ Evaluation and Research Consent Form (if applicable)

Please let us know:
Who you are happy for us to share your information with, by filling in the table below:

Please tick (✓)	**Please provide name**	**Please provide contact details (include address and phone)**
❑ GP / Doctor This is required under some of the programs offered by GPH. If you are concerned about this please discuss this with your health worker		
❑ Specialist Doctor		
❑ Nurse/Dietitian/Other Health professional(s) (eg. Community Mental Health and Mental Health Unit)		
❑ Family/Carers (eg. emergency contact)		
❑ School		
❑ Other (eg. Flourish Australia)		

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Please let us know if there is any information you don't want shared with the above listed people or services:
Please list (if any):
_____
_____

BY SIGNING THIS FORM:

You understand:

- the services being offered to you,
- your information will be kept secure (within an electronic health record),
- you are consenting to GPH sharing information relevant to your care with the people and or services above, including multidisciplinary case reviews with your GP,
- you are consenting to GPH obtaining information from the people and services listed above relevant to your care.
- only information relevant to the services that you receive will be kept,
- information may be used to help evaluate programs or review the work of the staff who work with you,
- your information (de-identified) may be used to report on the effectiveness of this program. You will not be identifiable in such reports,
- your information will not be released without your consent unless GPH is legally required to,
- you may withdraw this consent or change the details within this consent form, at any time by contacting Grand Pacific Health. Grand Pacific Health will still have some legal responsibilities to store your information for a period for time.
- If you are 14 years old or under, consent is required from a family member or carer.

Client signature: _____ Date: ____ / ____ / ____

Family/carer signature (if applicable): _____ Date: ____ / ____ / ____

Parent/guardian signature (if applicable): _____ Date: ____ / ____ / ____

Name of family/carer or parent/guardian: _____

Optional

- I agree to being contacted by SMS (text) messaging on this number 04_____

Please return to <insert applicable program contact>

Information on this form is collected, stored and released under Grand Pacific Health's Privacy Policy, Informed Consent Policy, Consent Procedure and Consumer Rights and Responsibilities