Informed Consent Form
Private Services

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

❑ GPH Rights and Roles Statement

❑ GPH Privacy Statement

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**		
❑ **Specialist Doctor**		
❑ **Other Health Professional(s)** (eg. Community Mental Health		
❑ **Family/Carers** (eg. emergency contact)	Name: Relationship:	
❑ **School**		
❑ **Other services** (eg. Flourish Australia)		

Please let us know if there is any information you <u>do not</u> want shared with the above listed people or services (please list, if any) _____
_____

Information on this form is collected, stored and released under Grand Pacific Health's Privacy Policy, Informed Consent Policy, and Consumer Rights and Responsibilities Policy. For more information www.gph.org.au/privacy-policy/

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Private Services

BY SIGNING THIS FORM, you understand:

- the services being offered to you;
- that access to the service is during office opening hours. GPH phones and emails are not constantly monitored throughout the day or on staff non-workdays. If you need urgent or emergency support please contact the Mental Health Line on 1800 011 511, Lifeline on 131114 and/or emergency services on 000;
- your information will be kept securely within a GPH electronic health record;
- you are consenting to GPH sharing information relevant to your care with the people and/or services listed above, and the health provider who referred you to GPH, this may include multidisciplinary case reviews;
- you are consenting to GPH obtaining information from the people and services listed above relevant to your care;
- if you are referred onwards to another service, your information will be shared with the service provider and other health professionals involved in your care;
- only information relevant to the services that you receive will be kept;
- within GPH your information may be used to help evaluate programs or review the work of the staff who work with you;
- your de-identified information may be used to report on the effectiveness of this program;
- 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; and
- if you are younger than 14 years old in NSW or 16 years old in the ACT, consent is required from a parent or guardian.

PLEASE NOTE: THIS CONSENT IS VALID FOR A PERIOD OF TWELVE MONTHS

Consumer signature: _____ Date: ____ / ____ / ____

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

Name of parent/guardian (required if applicable): _____

Name of GPH staff member collecting this consent_____ Date: ____ / ____ / ____

☐ Verbal consent was received via telephone/video conference on ___/_____/_____

☐ I was assisted to complete this form by _____

How to contact me:

- I agree to being contacted by SMS (text) messaging on this number _____
- I agree to being contacted via email at this address: _____@_____
- I am aware that this contact may include invitations to provide feedback on the service