ABLE TO WELLBEING

Consent to Share Information

Participant/client details:

Name:		Date of Birth:	
NDIS participant number:		Other client/reference number if relevant:	
Home phone:		Mobile number:	
Address:			
Email address:			

Representative / plan nominee / legally appointed decision maker:

Please only fill out the below section if the participant/client:

- Is under 18 years of age and you have parental responsibility, or are a child representative
- You are a plan nominee
- You are a legally appointed decision maker e.g. a guardian

Name:		Date of Birth:	
Home number:		Mobile number:	
Address:			
Email address:			

Key safe lock box code:

Please circle / tick next to the below relevant option

- I do not have a key safe lock box

- I consent to the use of my key and sharing of the key safe lock box code under the following circumstances

Key safe lock box code use:	Tick if yes
I consent to Able To Wellbeing accessing my key safe lock box in the event I am not answering the door and/or I am not responding according to the not at home plan.	
I consent to the key safe lock box code being shared with emergency services in the event I am not answering the door and/or I am not responding according to the not at home plan, and emergency services are called.	
I consent to my key safe lock box code being stored in Able To Wellbeing's clinical system so staff are able to refer to this code in the event it is needed.	
I consent to my key safe lock box code being shared with other service providers or family/friends/representatives who need to access my home in the event I am not answering the door and/or I am not responding according to the not at home plan.	

Sharing of information:

Explanations of where information may be shared:	Tick if consent given
I consent to my personal and health information being shared with my general practitioner / medical practice as noted below: Practice name: ________________________________ Preferred GP name: ____________________________ Phone number: ____________________ Fax: ______________________ Email: ____	
I consent to my personal and health information being provided to any GP within the above-named GP practice.	
I consent to my personal and health information being shared with any healthcare provider who is providing healthcare services to me where I have previously consented to that service delivery. This includes but is not limited to allied health practitioners, specialist medical doctors, pharmacists, other NDIS providers, other health care providers.	
I consent to my personal and health information being shared with the NDIS, NDIA or other government agencies as required for the delivery of my healthcare and wellbeing.	
I consent to my personal and health information being shared for the purposes of billing and payments.	
I consent to my personal and health information being shared to comply with legislative or regulatory requirements.	
I consent to my personal and health information being de-identified where required for the purposes of sharing information such as for research purposes or when requested by other organisations which support. This includes for research and quality improvement activities to improve individual and community health care.	
I consent to my information being uploaded to My Health Record which is a platform used by health professionals to share and review information.	

You may decline to have health information shared or used in some or all of the ways outlined above, or in other specific circumstances you request however it may impact on our ability to manage and support your health and wellbeing and to provide best outcomes for you. Please outline any additional circumstances or people/organisations in which you do not wish your information to be shared.

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Rights and consent:

Rights and consent:	Tick if yes
I confirm I have received a copy of Able To Wellbeing's Privacy Policy and Privacy Collection Statement.	
I understand the information contained in this Consent Form, Privacy Policy and Privacy Collection Statement which explains the information collected and where it may be shared.	
I understand that if my information is to be shared in any other way than outlined in this Consent Form, that Able To Wellbeing will obtain my consent.	
I understand that I can refuse to provide information or to have my information shared, but that this may impact on Able To Wellbeing's ability to provide high quality care and best outcomes.	
I understand that this consent lasts for 12 months, but I may request to update or change my consent at any time. If I wish to do this, I will notify Able To Wellbeing.	
I have been informed of the potential risks and benefits associated with the proposed health services, and I have had the opportunity to ask questions and seek clarification.	
In the event of an emergency where I am unable to provide consent, I authorise Able To Wellbeing to undertake emergency medical treatment and notify the relevant representatives or other organisations as deemed necessary.	
I have the right to revoke this Consent Form approval at any time by providing written notice to Able To Wellbeing. However, I understand that revoking consent does not affect any health information that has already been shared.	

Able To Wellbeing representative name: ____

Able To Wellbeing representative position: ____

Able To Wellbeing representative signature: ____________________________ Date: __________

Client/Participant name: ____

Client/Participant signature: ____ Date: __________

Representative of Client/Participant name: ____

Representative of Client/Participant signature: _________________________ Date: ___________

Note: verbal consent can be provided by the client/participant or representative. Where this occurs, this will be documented in the information system as a verbal consent. Able To Wellbeing will still discuss and complete this form with the client/participant and/or the representative.