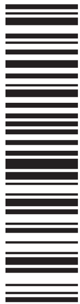
Health
South Eastern Sydney
Local Health District

Facility: Adahps

CONSENT TO OBTAIN AND SHARE PERSONAL INFORMATION

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ______ / ______ / _______	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	



SES020024

Adahps needs your permission to obtain and share your personal details with other services that provide support to you (e.g. community workers, housing providers and private contracted workers).

You should only sign this form when you understand what is being asked of you.

I, ______________________________________ give permission for Adahps to obtain details about my health/ situation and for Adahps to share this with other services when it's needed for my care, or to ensure the safety of those working with me.

This consent will last for two years unless I withdraw it.

Adahps will not ask for or share information about me that is not relevant to the services they are providing to me.

Legal limitations to confidentiality may potentially require a staff member to disclose your information to a third party without your consent, for example where:

1. The staff member is concerned that you may harm yourself or others;
2. A child or young person is at risk
3. A Court of Law instructs us to disclose your information

I have been given and understand the:

- *NSW Health Information Privacy Leaflet* — *Yes / No*
- *Consumer and Carer Rights and Responsibilities Brochure* — *Yes / No*

I understand the implications of giving my consent and give permission to obtain and share my information as outlined above.

Family Name:	Given Name:	Date of Birth:
Street Address:		
State:	Postcode:	Phone:
Signature of client:		Date:
Or Signature of person acting on behalf of client:		Date:
Name:	Relationship:	
(Proof required if Guardianship order applies)		

DO NOT PRINT

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

CONSENT TO OBTAIN AND SHARE PERSONAL INFORMATION

SES020.024

S1148 101220

NO WRITING