Consent Form

– to collect and use my personal health information

I agree that IPC Health can set up and keep a health care record for me or the person of whom I am the legal guardian/agent.

To assist in providing the best possible care, I agree that all health providers engaged in providing me with care at IPC Health can look at my health care record or the health care record of whom I am the legal guardian/ agent

To help plan and improve service, my information or the information of the person of whom I am the legal guardian/agent may be given to funders of the service. This information will have names and addresses removed.

My health care worker has informed me IPC Health will report back to the agency that has referred me, or the person of whom I am the legal guardian/agent.

All the information collected by IPC Health will be kept confidential unless:

- Failure to disclose that information would place you or another person at risk of harm,
- It is subpoenaed by a court,
- Your prior approval has been obtained (for example to release a report or participate in case planning)
- We may disclose your personal details to the Victorian Department of Health or its authorised contractors, in order for them to send you a survey about your experience with us
- A regulatory body requests the information, or
- the information is otherwise required to be disclosed by law.

My health care worker has informed me of my right to access my health information or the health information of the person for whom I am the legal guardian/agent.

Client Name: _____DOB:_____UR_____

Consent Details

I understand and agree that IPC Health can provide information to the recipients outlined above.

Name:_____Relationship to client: _____

Signed_____Dated: _____

Interpreter Name: _____

Interpreter Signature_____Dated: _____

Receiving and sharing information about you

You must agree and give us your written permission to share information about you or the person of whom you are the legal guardian/agent.

Client Name:_____ **DOB:**_____ **UR:** _____

Person For example, my doctor	**Where the person works** For example, the name of the clinic	**Type of information** For example, my test results	**Obtain** (receive from)	**Disclose** (give to)	**Reason** For example, to change my medicine

Consent Details

I understand and agree that IPC Health can receive information from outside agencies and provide informationto outside agencies

Name:_____ Relationship to client: _____

Signed_____ Dated: _____

Interpreter Name: _____

Interpreter Signature_____ Dated: _____

Refusal of consent

I do not give my permission for IPC Health to provide any information to any recipients.

Signed_____Dated: _____