# Information Consent Form



**Name: ...........................................................................**

**Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_\_**

**headspace** Sale is a youth mental health service and a program of Relationships Australia Victoria. To provide you with a good service, we need to collect some of your personal information.

The privacy and confidentiality of your information is important to us.

We are required to give some information about you (NOT your name or address) to our funding body, Department of Health. Information that will be given will be for example: your age, gender or how many times you used the service.

Please read this document carefully and talk to your worker if you have any questions or issues before signing it.

**What happens with information at headspace?**

* We will collect some information and write some notes about the reasons you have come to headspace. These are stored as either a hard copy in a locked filing cabinet, or electronically on a password protected database. Access is restricted to **headspace** clinicians.
* **headspace** Sale staff and co-located health professionals hold care plan meetings to discuss cases to ensure that the highest level of care is provided.
* If we want to speak with your family/carer/friends or another service to assist in your treatment and care, we need your written permission (below).
* If you would like a copy of any notes about you, you may request these and there is a process for providing these.
* Our policies and staff members conform to the Health Records Act (Vic) 2001 and Privacy Act 1988 and all other relevant Government laws and regulations.

**Consent**

I give permission for **headspace** Sale to share my information with the following people:

[ ]  **headspace** Sale team

[ ]  Family member and/or friend ……………………………………………………………………….

[ ]  Medical and mental health providers (for example: Mental health workers, GPs, Nurses, Specialist doctors, Psychiatrists):

 …………………………………………………………………………………………………………

[ ]  Healthcare professionals (i.e. Psychologists, Counsellors, Social Workers)

 ………………………………………………………………………………………..……………….

[ ]  School professionals (e.g. teachers, School psychologists, School Social workers, School counsellors, Pastoral support workers).

 ..……………………………………………………………………………………………………….

[ ]  Other (e.g. Case manager, Employment consultant)

 ………………………………………………………………………………………………………...

* I know that I can change my permission at any time.
* This permission is only valid while I use **headspace** Sale services.

**My worker has explained the following to me: (please tick)**

[ ]  Information about confidentiality, privacy laws and how my information is kept in a file.

[ ] Sometimes headspace Sale workers may have to break confidentiality to keep me and others safe.

[ ]  This is a voluntary service and I can choose to leave and not come back at any time.

[ ]  If I have any worries about the service I receive, I can talk to my **headspace** worker or contact the Centre Manager of **headspace** Sale.

[ ]  I can choose to involve family/ carers/ friends/ others in my care and consent to them being given a copy of their rights and responsibilities.

[ ]  When I have signed the consent form, **headspace** workers can share my information with the workers and others that I listed on it.

[ ]  I understand that **headspace** workers may need to speak about my current Legal orders with other people such as parents/guardians and/or other workers.

[ ]  I have the right to request access to my electronic or paper file.

[ ]  I have the right to give feedback or make a complaint.

[ ]  I have the right to high quality and safe healthcare.

[ ]  I have rights *and* responsibilities in accepting care and treatment, and have been given a copy of the Young People’s Rights and Responsibilities form.

[ ]  I am aware that **headspace** Sale will give some information about me (*NOT* my name or address) to the funding body, Department of Health.



**Signed: …………………………………… Date:……………………………….**

***I am under 16 years old:* yes**[ ]   ***no*** [ ]

***(If you answered ‘yes’ to the previous question please have your Parent/ Guardian sign below)***

***Parent/ Guardian’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_***

|  |  |
| --- | --- |
| **Do you have any current Legal Orders?**  | [ ] Yes [ ] No |
| If YES, please tick | [ ] Child Protection Order(s)  | [ ]  Family Court Order(s) |
|  | [ ] Intervention Order(s)  | [ ] Other (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

If YES and you are under 16 years old, please provide **headspace** Sale with a copy of each current Order for our records. NB: We will need to speak with your parents/guardian/carer about these orders.

**Please make sure you have viewed the headspace Information and Consent video.**

If you have any questions or concerns about the content of the video please speak to your headspace worker.

To show you have read and understood this form, please *tick* the boxes below:

[ ]   **I have viewed the headspace Information and Consent video.**

[ ]  I understand this information.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_/\_\_\_\_\_/ 20\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| I am under 16 years old: | [ ] Yes  | [ ] No  |

If you are under the age of 16 a paper copy of the Information and Consent video content can be sent home for your parent and guardian to sign.

***Office use only***:

Personal Information and Privacy form provided & explained to client**:**

**Worker’s signature: ………………………………………………….**

**Worker’s name/role title: ……………………………..…………………..**

**Date: ……………………………………………….…**