AMPEY PTY LTD
PARTICIPANT CONSENT FORM

Provider Declaration:
AMPEY PTY LTD will work closely with other agencies to coordinate the best support for you. We need your consent to share your information, except when: • we are obliged by law to disclose your information regardless of consent or otherwise. • it is unreasonable or impracticable to gain consent or consent has been refused; and • the disclosure is reasonably necessary to prevent or lessen a serious threat to the life, health or safety of a person or group of people.

Participant's Details:			
Name:		**Date:**	

Participant's or Authorised Representative Declaration:
I acknowledge that the organisation has advised me of the following: • Privacy and Confidentiality Policy and Procedure. • My right to access my personal information; and • My right to withdraw my consent at any time. • AMPEY PTY LTD has advised me that this form needs to be completed **once every 12 months** or if I change my mind on what I consent for AMPEY PTY LTD to support me with. **I can change my mind and withdraw consent at any time.**

Participants Consent:
I give consent to: • Store information about me – (AMPEY PTY LTD will store your information for 7 years after the cessation of the service as stipulated by the NSW Government State Records - 'General retention and disposal authorities). • Allow staff, who need my information to provide services to me, to access information about me. • Share my information ***except*** with the people and/or organisations listed below. • Give Verbal consent - this will only be used where it is not practical to obtain written consent.

Parties Excluded from Information Sharing
Information must not be shared with the following people or organisations:

Signature	
Name of participant or authorised representative:	
Signed:	***Date:***

Sharing Information:

Do you consent to AMPEY PTY LTD sharing your information with:

Person/ provider	Yes	No	Name of person/ provider
GP			
Speech Pathologist			
Occupational Therapist			
Physiotherapist			
Behaviour clinician			
Neurologist			
Mental Health Practitioner			
Psychologist			
Other Specialist (please specify)			
External support services			
Nominated Coordinator of Supports			

Do you live in a SIL or receive support from another provider? *If yes, please name the provider:*

Yes **No**

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Do you want AMPEY PTY LTD to share information about your supports with your immediate family?

Yes **No**

People I consent to having my information shared with:

_____

_____

People I DO NOT consent to having my information shared with:

_____

_____

General Consent

Do you consent to staff learning more about you and **receiving information from a range of sources** e.g Allied health reports, observations, progress notes, medical documentation/reports? This will also help us provide you with the best support.

Yes **No**

Do you consent to staff **collecting information** about you that helps us provide you with the best support? This might include written information e.g reports, procedures, supports plans, 'About me' forms. This information may be given to allied health services and kept in participant files.

Yes **No**

Do you consent to staff supporting you to access the community, to go on special outings or to go on holidays?

Yes **No**

Do you consent to staff supporting you with your money as required or appropriate for the occasion?

Yes **No**

Do you consent to staff supporting you with your health outside of what is required of any allied health plans e.g headache management, vomiting, infectious disease control management?

Yes **No**

Do you consent to staff supporting you with your medication?

Yes **No**

Do you consent to staff supporting you with personal care?

Yes **No**

Do you understand that during your support at AMPEY, if you are presenting a severe medical concern, staff will call an ambulance and then inform your next of kin. We will provide emergency services with the necessary information required for treatment.

☐ **Yes, I understand**

General Media Consent			
I consent to AMPEY PTY LTD to use, post and reproduce the following material:			
Educational purposes *(e.g Allied health reports, visual procedures)*	☐ Video	☐ Photo	☐ I DO NOT consent for either
Participant specific needs *(e.g Progress reports, skin integrity report, data collection, incident reports)*	☐ Video	☐ Photo	☐ I DO NOT consent for either
Shared with Family/Foster family *(e.g via email, messages, client communication portal)*	☐ Video	☐ Photo	☐ I DO NOT consent for either
Shared with SIL providers *(e.g via email, messages, client communication portal)*	☐ Video	☐ Photo	☐ I DO NOT consent for either
Posts to social media *(Facebook and Instagram)*	☐ Video	☐ Photo	☐ I DO NOT consent for either
AMPEY PTY LTD Website	☐ Video	☐ Photo	☐ I DO NOT consent for either

Do you have any comments you wish to add regarding your consent?

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_____

_____

Signatures:

Participant Name:	
Participant Signature:	
Date:	
Guardian or Authorised Representative Name:	
Relationship to Participant:	
Signature:	
Date:	