The information about you that we collect is confidential. We have systems in place to ensure that your records are safe and only authorised people have access to the information. We can explain the processes to you in detail if you wish. We can only ask you about things that contribute to the support we provide to you.

In order to provide you with a safe and seamless service we need to share information with people that provide other services to you. The following agencies, health professionals or people may require some information about you or you may choose to have them informed of specific information. If possible, we will inform you before we exchange information:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Agency/Health Professional or other | Type of information to be shared | | Information | | Date | Signature of person giving consent |
| Requested from: | Given  To: |
|  |  | |  |  | Click here to enter a date. |  |
|  |  | |  |  | Click here to enter a date. |  |
|  |  | |  |  | Click here to enter a date. |  |
|  |  | |  |  | Click here to enter a date. |  |
| People/whānau you want us to share information with: | | | | | | |
| Name | | Type of information | | | | |
|  | |  | | | | |
|  | |  | | | | |
|  | |  | | | | |
| I have been informed that there will be audits by government organisations. The auditors will need to see my health records to assess whether the care I am getting is acceptable and according to the contractual obligations and standards. Some government agencies might (example: CYFS, coroner) request information about you. | | | | | | |
| **We will not ask you for permission to exchange information if there is an imminent risk to you or another person and to mitigate the risk we will need to share some information with the person that can address the risk.** | | | | | | |
| **Comments:** | | | | | | |
| **I have been given information about** [**PRIMHD**](http://www.health.govt.nz/system/files/documents/publications/primhd-brochure-24apr-2012-1.pdf)**. yes  no** | | | | | | |

Review of this consent will occur no later than: Click here to enter a date.

I (Name) Click here to enter text. NHI Click here to enter text. have understood how this service

will manage the information they have about me.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: Click here to enter a date.

Staff Click here to enter text. Designation: Click here to enter text.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: Click here to enter a date.