RELEASE OF INFORMATION CONFIDENTIALITY AGREEMENT

I , , hereby agree that information regarding my medical condition and support needs may be released by my general practitioner or other medical, hospital or allied health staff, Support Coordinator or other engaged services to authorised staff of AQC for the purpose of assessing my care needs and to develop an assistance/ Treatment plan.

I acknowledge that AQC staff may need to discuss my situation with appropriate professionals and nominated carers and agree to such discussions taking place on the understanding that I will be informed of the outcome.

I understand that only information necessary for service delivery or assessment or treatment will be exchanged, and that such information will not be divulged to other persons without my permission. Medical and other private information will be kept in my personal file which shall be held securely by AQC and not be accessible to any unauthorised person.

I understand that non-identifying information will be used for the purpose of reporting to the funding body and for internal and external Quality improvement processes.

I DO/DO NOT give consent to taking of photographs for the purpose of identification, wound care and promotional activities. I understand employees will explain the purpose of each photo before it is taken.

I understand that I may have access to my personal file on written request, giving l4 days' notice. I understand that I may withdraw my consent to release of information at any time.

I have received the following information AQC welcome pack including, AQC Privacy policy.

Consumer Signature_____Date: / /

Advocate / Representative Signature_____Date: / /