**Client Consent Form**

ZedCare Ability Services will work closely with other agencies to coordinate the best support for you. This means your informed consent for the sharing of information will be sought and respected in all situations unless:

* 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.

I, David Nicholls hereby acknowledge that ZedCare Ability Services has advised me of the following:

* ZedCare Ability Services *Privacy and Confidentiality Policy and Procedure*;
* my right to access my personal information; and
* my right to withdraw my consent at any time.
* I understand that the follow service(s) are recommended and relevant information about me may be forwarded to the agency(s) that provide these services, in order that I receive the best possible service:

ZedCare Ability Services

* I understand that ZedCare Ability Services must comply with relevant privacy laws and I will contact the organisation immediately if I feel that these laws have been breached.
* My worker has discussed with me how and why certain information about me may need to be provided to other service providers.
* I understand the recommendations and I give my permission for the information to be shared with the people or agencies as detailed above.

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| Name of Client or Authorised Representative | Signature | Date |
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| Name of <clinic> Staff Member | Signature | Date |

**Staff use only**

**Verbal Consent**

Verbal consent should only be used where it is not practicable to obtain written consent.

I have discussed the proposed referrals with the client or authorized representative and I am satisfied that they understand the proposed uses and disclosures and have provided their informed consent to these.

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| Name of <clinic> Staff Member | Signature | Date |