TRIAL

Queensland Government

Royal Brisbane and Women's Hospital

Working Together to Connect Care Program

CONSENT TO SHARE INFORMATION

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Things you need to know

Why does the hospital need this information?

- Hospitals cannot give out your personal or medical information to a non-government agency without your permission. The hospital needs you to sign this form to be able to talk to and share your information with these agencies so you can start working together.
- Any work that you do with the non-government agencies is decided between you and the agency.

Can I change my mind and withdraw my consent?

- Yes, you can change your mind at any time. If you change your mind after the hospital has talked to the non-government agency about you and shared your medical information – you will need to talk to the agency to tell them about your decision.
- Your consent will remain current unless you withdraw it.

Can I have a copy of this form?

- Yes. As soon as you sign this form, you should be given a copy by the staff member. If they do not do this – please let them know that you want your copy.

☐ I have received a *'Working Together to Connect Care'* program brochure.

☐ I have had an opportunity to read and/or discuss the *'Working Together to Connect Care'* program with a hospital staff member.

Purpose

When you sign this form you agree that:

- This program has been explained to you and you want to work with non-government agencies.
- The hospital staff can share your medical information with non-government agencies to help you.
- The hospital can organise meetings and talk with non-government agencies about how you, the hospital and the non-government agencies can work together to help you. You understand that you can be part of these meetings.

Consumer authorisation

Full name: ..... Signature: .....

Date: ... / ... / ... Best contact number: .....

Witness

Full name: ..... Signature: .....

Designation: ..... Date: ... / ... / ...

Telephone: ..... Work: ..... Mobile: .....

Office of Public Guardian

Full name: ..... Signature: .....

Date: ... / ... / ... Contact number: .....

Please specify any restrictions or instructions:

.....

Office use only

To what community organisation was the patient referred? *(please print)*:

.....

☐ Patient did not grant consent Date: ... / ... / ... ☐ Patient withdrew consent Date: ... / ... / ...

CONSENT TO SHARE INFORMATION

DO NOT WRITE IN THIS BINDING MARGIN

MR A CON 7437

V1.00 - 08/2016

Locally Printed

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