CLIENT CONSENT FORM FOR DISCLOSURE OF INFORMATION

Name…………………………………………………………………………………………………………………………………………………..

Address………………………………………………………………………………………………………………………………………….....

Post code ……………………………………

* I give permission for (Provider), my GP practice and other services to share personal information with other service providers in connection with my care.
* This includes accessing and sharing my medical, and if applicable mental health and police records.
* I agree to referrals being made to service providers that may be beneficial in order to support my needs.
* I understand that (provider) may hold information gathered about me from the various agencies and as such my rights under the Data Protection Act will not be affected.
* I can choose to withdraw my consent at any time by speaking to my HIU Lead (or equivalent) or emailing …..

Signature of client……………………………………………………………………………………….

Printed name: …………………………………………………………………………………………….

Date:…………………………………………………………………………………………………………..

Signature of Witness: ………………………………………………………………………………….

Printed name:……………………………………………………………………………………………..

Date:…………………………………………………………………………………………………………….