

## Consent to Share and Protect Your Personal Information

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

NHS number: \_\_\_\_\_  
Adult & Community Services reference: \_\_\_\_\_

### Your Statement of Consent

Please read this carefully, complete the restriction box if appropriate and then sign, and date the form. If you have any concerns please discuss them with a member of staff.

I **agree** that the information provided in my assessments may be shared with Health and Social Care staff, Service Providers who can contribute to my care and any agencies acting on behalf of these organisations.

I **understand** that this information will be used for the purpose of providing a service, or care to me. I also **understand** that agencies may use anonymised information for statistical purposes and that the law may allow in some circumstances for other agencies to be provided with information about me.

I **understand** that I may withdraw my consent to share information at any time and this may result in a reduction of services being available.

I **understand** that I have the right to restrict what information may be shared and with whom, but this may affect the provision of care to me.

I **understand** that my information will be held securely on paper and on computer in accordance with the Data Protection Act 1998.

**I have made the following restrictions:** (if applicable)

Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Print Name: \_\_\_\_\_

**In order to alter your consent, please inform the office who have most contact with you.**

### Statement of Representative (if applicable)

I represent the person named on this form and:

I am happy with the decisions that have been made concerning the sharing of information

I am unhappy with the decisions that have been made concerning the sharing of information

because:

Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Print Name: \_\_\_\_\_

Relationship to person: \_\_\_\_\_

Source of Legal Authorisation, if applicable (e.g. LPA): \_\_\_\_\_

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

NHS number: \_\_\_\_\_  
Adult & Community Services reference: \_\_\_\_\_

**Statement of Practitioner**

Is the person able to understand why their information may be shared and are they able to make a consent decision on this basis? (Please tick and complete **A**, **B** or **C** below).

**A** Yes

and I have explained to the person/their representative:

Why we may need to share information.

Who we may need to share information with - *(please list if outside of Health/Social Care e.g. a Housing or Voluntary Agency provider)*.

Their right to decline the sharing of some or all of the information

Their right to withdraw consent at any time.

I have given the person/their representative a copy of the Single Assessment Process Information Leaflet.

The person has signed this form overleaf.

**or**

I have explained the above during a telephone call, and the person has given their consent **verbally**.

**B** I am unable to judge this and have referred this matter to:

**C** No, because:

**Review of Consent**

This consent form should be reviewed at the completion of any new assessment to ensure that it still reflects the person's wishes.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Print Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Organisation: \_\_\_\_\_

Role in Organisation: \_\_\_\_\_