South Coastal Health and Community Services / South Coastal Babbingur Mia collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and proactively address your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes such as creating your client electronic file;
2. Billing purposes including compliance with Medicare;
3. Disclosure to others involved in your physical and mental health care including other staff members within the organisation and your referring doctor outside of the organisation as required by Medicare Australia.

**Client’s Rights**

* I have the right to confidentiality as outlined in the Privacy Act. This applies to all records and information collected and retained by South Coastal Health and Community Services. All information shall be kept strictly confidential and will not be shared or revealed to any person, agency, or organisation without the prior written consent from myself, except where South Coastal Health and Community Services is legally obliged to release my information, such as is in the situations outlined below:
* Subpoena – This is a legal document issued by the Court requesting information / documentation.
* Ethical/Duty of Care – Where there is clear possibility of self-harm or harm to others.
* I understand my information must be collected and retained to support my health care;
* I understand that I am not obliged to provide any information requested of me, but that failure to do so might compromise the quality of the health care and treatment given to me;
* I am aware of my right to access the information collected about me, expect in circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances;
* I consent to the handling of my information by South Coastal Health and Community Services for the purpose set out above;
* I understand that at any time I may withdraw my consent by advising South Coastal Health and Community Services / South Coastal Babbingur Mia in writing;
* I understand that this consent form applies to all services offered by South Coastal Health and Community Services / South Coastal Babbingur Mia and is valid for 12 months.

**Consent to Collect and Disclose My Personal Information**

By ticking this box **I give consent** for my personal details to be collected and used for reporting, auditing, research and evaluation purposes by South Coastal Health and Community Services / South Coastal Babbingur Mia. I understand that my medical information will be released as outlined within the Privacy Act and additional amendments. I understand I may withdraw my consent, in writing, at any time.

By ticking this box **I do not give consent** for my personal details and medical information to be shared at any time or used for reporting, auditing, research and evaluation purposes. I understand as noted above there maybe exceptional circumstances where information is required to be disclosed.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name) give my consent to South Coastal Health and Community Services/Babbingur Mia to collect and disclose my personal information as outlined above.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name) Parent/Guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

give my consent to South Coastal Health and Community Services /Babbingur Mia to collect and disclose personal information regarding my child as outlined above.

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

Please list any organisations you do not wish your personal information or records to be shared with:

**Parenting Support Consent**

I provide consent for Creche Workers to share information regarding my child with my clinician at South Coastal Health and Community Services, for the purposes of receiving and exploring this feedback in session.

I understand that I am able to withdraw my consent to participate at any time by advising my clinician.

 **Client Full Name** **Signature**  **Date**

  **Full name of Child/Children**

**For Clients of Babbingur Mia Only**

**Primary Mental Health Care Minimum Data Set. Some of our services use a different database.**

The PMHC MDS data is used as an evidence base by the Australian Government’s Mental Health Drug and Alcohol Principal Committee to determine future Government investments in the Australian mental health system and, in particular, Primary Health Networks such as WA Primary Health Alliance (Funder of Service). It is important that we record improvements in social and emotional wellbeing to demonstrate the benefits of services received by community members under this project.

If you consent to your information being shared with this Database, please sign here:

**I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name) give my consent to Babbingur Mia to collect and disclose my personal information as outlined above.**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**