

Easy Read - Participant Information Consent Form




The following information has been explained to me (check yes or no):

1. Collection of my personal information

<input type="checkbox"/> Yes <input type="checkbox"/> No	 <p>I understand that if I say yes (or I agree to something) I am giving my consent.</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	 <p>I agree (give my consent) that my provider can collect information about my health, needs, interests, and goals.</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	 <p>I agree that auditors can look at my information when doing an NDIS audit.</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	 <p>I understand my funding bodies might need to look at my information for an audit review.</p>

2. Information collection for support/service delivery




I give consent (agree) for my provider to record information in different ways to deliver my supports/services. I agree they can use:

<input type="checkbox"/> Yes <input type="checkbox"/> No	 <p>Photographs.</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	 <p>Voice recordings.</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	 <p>Videos.</p>

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3. Provider marketing – consent to using my image

I give consent (agree) for the provider to use my image in their marketing material (e.g. on their website, in newsletters):

<input type="checkbox"/> Yes <input type="checkbox"/> No	 Photographs.
<input type="checkbox"/> Yes <input type="checkbox"/> No	 Voice recordings.
<input type="checkbox"/> Yes <input type="checkbox"/> No	 Videos.

4. Sharing my information with practitioners and workers

I give consent (agree) to all relevant information being shared with:

<input type="checkbox"/> Yes <input type="checkbox"/> No	 Health care professionals (including allied health).
<input type="checkbox"/> Yes <input type="checkbox"/> No	 People who work with me to deliver my supports/ services.

5. Recording my information

I give consent (agree) for the following people to collect and record my personal information:

<input type="checkbox"/> Yes <input type="checkbox"/> No	 My provider.
<input type="checkbox"/> Yes <input type="checkbox"/> No	 My health care professionals (including allied health).
<input type="checkbox"/> Yes <input type="checkbox"/> No	 People who work with me to deliver my supports/ services.

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6. Access to personal information

I understand I can request to see my personal information:

Yes No



I know I can ask my provider to see my personal information at any time.

7. Correction and destruction of information

I understand I can request changes to my personal information:

Yes No



I can tell my provider if any information about me is incorrect, and they will fix it.

Yes No



I can tell my provider if any information is wrong, and I want it destroyed.

Participant/Advocate Name: _____

Signature: _____

Date: _____

Staff Name: _____

Role: _____

Signature: _____

Date: _____