

Participant Information Consent Form

Easy Read

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

1. Collection of my personal information

Yes	✓	No	✗		<p>I understand that if I say yes (or I agree to something) I am giving my consent.</p>
Yes	✓	No	✗		<p>I agree (give my consent) that my provider can collect information about my health, needs, interests and goals</p>
Yes	✓	No	✗		<p>I agree auditors can look at my information when doing an NDIS audit</p>
Yes	✓	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:

Yes ✓	No ✗		Photographs
Yes ✓	No ✗		Voice recordings
Yes ✓	No ✗		Videos

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):

Yes ✓	No ✗		Photographs
Yes ✓	No ✗		Voice recordings
Yes ✓	No ✗		Videos

4. Sharing my information with practitioners and workers

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

Yes ✓	No ✗		Health care professionals (including allied health)
Yes ✓	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:

Yes ✓	No ✗		My provider
Yes ✓	No ✗		My health care professionals (including allied health)
Yes ✓	No ✗		People who work with me to deliver my supports/ services

6. Access to personal information

I understand I can request to see my personal information:

Yes ✓	No ✗		I know I can ask my to see my personal information at any time
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7. Correction and destruction of information

I understand I can request changes to my personal information:

Yes ✓	No ✗		I can tell my provider if information about me is incorrect and they will fix it
Yes ✓	No ✗		I can tell my provider if information is wrong and I want it destroyed

Participant/advocate name:

Signature:

Date:

Staff name:

Role:

Signature:

Date: