Consent Form

headspace Port Lincoln

Surname:	First Name:	Date of Birth:

Consent for support

☐ I consent for **headspace** Port Lincoln clinicians and support workers to provide support to me which may include a range of assessments and intervention services.

☐ I understand that the service is voluntary, and consent is valid while I am a current client of **headspace** Port Lincoln. I understand I can CHANGE or WITHDRAW my consent at any time

☐ I understand **headspace** Port Lincoln does not provide emergency services or after-hours care

☐ I understand my details will remain confidential, unless there is a serious risk of me harming myself, harming others or if a crime has been committed.

Consent to Exchange information

☐ I consent to my information being provided to Country SA Primary Health Network or to the Department of Health to be used for statistical and evaluation purposes designed to improve health services in Australia.

☐ I give permission for staff from **headspace** Port Lincoln to release and exchange information to the people or agencies listed below to assist me in my care:

- ☐ **Country & Outback Health (headspace** team) & mental health services (e.g.CAMHS or EMHS)
- ☐ Family member/ significant other ……
- ☐ Doctor ……
- ☐ School/ work ……
- ☐ Job support agency ……
- ☐ Legal ……..
- ☐ Other …….

But not including information regarding:……..

……

Although unlikely, SMS and email may be intercepted and read by people it is not intended for.

☐ I understand Country & Outback Health cannot guarantee the security and confidentiality of SMS and Email and I consent to communication via:

☐ SMS Mobile number:	☐ Email Email Address:

☐ I have received the **headspace** Port Lincoln Rights & Responsibilities brochure & Welcome Pack via SMS

☐ I have **NOT** received the **headspace** Port Lincoln Rights & Responsibilities brochure & Welcome Pack via SMS

Client signature..... Date

Carer signature..... Date
(If client is under 16 years)

Carer Name .....

Signature Obtained (please circle) In Person Over the Phone

Staff Name .....

Staff signature…..... Date

***This consent form is valid for 12 months*