

# INFORMATION SHARING AND CONSENT FORM

**The name of the child, young person or adult we are keeping records on.**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**I confirm that I understand the following:**

- \* The reason I have been referred to the service or am getting involved with The Children's Society.
- \* Why The Children's Society needs to keep information about me.
- \* What kind of information is kept.
- \* Who The Children's Society will share my information with.
- \* Who I can contact if I am unhappy with anything about The Children's Society.
- \* The situations in which The Children's Society will need to share information without my permission.
- \* What my rights are about my information.

## Safe in Essex/Family Intervention Team Consent

1. Do you consent to enter into non substance use specific treatment services with us?  Yes  No
2. Do you consent to having your information stored on the case management system operated by The Children's Society?  Yes  No
3. Do you understand your right to withdraw consent at any point?  Yes  No

## Information sharing and consent

In order to provide you with joined-up and effective support and treatment with other services, we may need to share your information with other professionals. This may include sharing your assessment and care plan information as well as any on-going communication. This will only take place with your written permission which will be obtained during your assessment, and recorded on the consent to share information field as part of this. If you wish for us to have contact with any of your family members or any other significant person(s) this will also take place with your written permission.

**Please sign below to confirm your preferences as indicated on the form above and to confirm receipt of the relevant service information sheet and confidentiality booklet;**

Client name: \_\_\_\_\_ Client signature: \_\_\_\_\_

Key worker name: \_\_\_\_\_ Key worker signature: \_\_\_\_\_

Date: \_\_\_\_\_ Client number: \_\_\_\_\_

**Information sharing list**

**The client should give details for the person who should be contacted in case of emergency:**

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

Contact number: \_\_\_\_\_

Relationship to child, young person or adult: \_\_\_\_\_

**List below all those people the client will allow information to be shared with.**

Name of person with whom information can be shared	Relationship to client	Client signature	Date	Client should sign in this column if they wish to remove consent to share information with the named person	Date



**Please sign below to confirm your preference as indicated above and confirm you have received information about the service and the confidentiality booklet or watched the video clip.**

Signature of child, young person or adult \_\_\_\_\_ Date \_\_\_\_\_

**If 13 or under, the person with parental responsibility to complete.**

Name \_\_\_\_\_

Relationship to Young person \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_