

Information Sharing and Consent

Service user name:		NHS Number:	
Date of Birth:		Date:	

In order to support you in your recovery we often need to share personal information with others who are involved in your care. Working in partnership with others is our routine practice.

We work with people such as your GP, other NHS Trusts, social services where they are not part of AWP, private care providers, schools, colleges and universities. We also work in partnership with your family and carers.

We will tell you who we may be sharing information with and the reasons for this. We will try to agree this with you. If you don't agree, we will discuss with you the possible effect this may have on your care and the alternatives available.

We will also share information with you, such as copies of letters between professionals about your care. You will also be sent information about research studies that may be of interest to you.

We will discuss with you the different types of information which could be shared. If you decide that you don't agree to all types of information being shared you might feel happy to share some general information, for instance if you rely on others to help you remember when you have an appointment you might want us to share copies of your invitation letters with them.

In certain circumstances, there may be occasions where it is necessary to share information without your consent. This will only be where we are required to by law and the Data Protection Act. For example information may be shared where it is in the public interest to protect somebody else from significant harm. In these circumstances the information shared will always be kept to the minimum necessary in law.

Please record any types of information you do not want to share and if there are any people who you do not want us to share information with please give us their names/addresses and indicate their relationship to you.

Service User Signature:		Print Name:	
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Were any concerns identified with regard to the service users capacity to make decisions about information sharing raised during your discussion about information sharing?: Yes/No (If yes, complete RiO mental capacity assessment).

Healthcare Professional Signature:		Print Name:	
Job Title:			