Your Health Care Provider will explain this information to you and provide you with a written copy.

Your Rights.

**When working with APMHA you have the right to:**

**ACCESS:** Access health care & ask questions about your health care. You can ask to see information & ask to change information if it is wrong.

**SAFETY:** Safe, high-quality care and the right to change services if you feel unsafe.

**RESPECT**: Be treated with dignity and respect. This includes respect for your culture, age, gender, religious / spiritual beliefs, sexual orientation, disability, self-determination, experiences, values and beliefs.

**COMMUNICATION:** Be told about services, options and costs in a way that you understand. We will find an interpreter if you need one and tell you about other service providers if they can better meet your needs.

**PARTICIPATION:** Be included in decisions about your care and take the time you need when selecting your supports. You have the right to say no to any services at any time.

**SUPPORT:** Have someone you trust to support you when working with APMHA.

**COMMENT and COMPLAIN:** Comment on your care and to have your concerns addressed. It is okay to complain. Your complaints lead to better services.

**PRIVACY:** Your personal information being kept private and confidential.

**With your consent, your family, carers and/or supporters have the right to:**

* Be treated with dignity and respect at all times
* Be recognised, respected and supported as partners in your care
* Be involved in providing information to the provider that can help your care and recovery
* Receive information about your condition, its likely causes, service options and outcomes
* Have their rights explained and receive a copy of this charter
* Be supported in their caring role.

Consent to share information

To provide you with the best possible health care, we may need to talk to and share your information with your GP and/or nominated support team or we might use the information we collect about you to improve our services and report to our funders. We will need to share information when you start using APMHA services or when you move from APMHA to another service or from another service to APMHA. Your consent is required to share this information.

We provide regular progress to your GP or support team to make sure our services are still meeting your needs. We let your GP know when you have finished counselling so they can help you maintain your mental health.

All information sent to or from APMHA remains confidential between you, APMHA and the health professionals you agree can have that information. You can request a copy of any information we shared at any time. All de-identified information collected remains confidential and will be stored securely.

If you or your supporter/s are involved in a serious injury, physical assault, sexual misconduct, or abuse or neglect, APMHA is required by law to share identifiable information with the NDIS Commission or our funders. This information includes your name, address, date of birth, gender and information about your condition. We must report even when the incident alleged and not proven.

If, after reading each of the statements above, you are happy to progress, please complete and sign the client consent section provided.

|  |  |  |  |
| --- | --- | --- | --- |
| **Who is consenting to the collection, use and disclosure of personal health information:** | | | |
| Adult providing consent for self  Guardian, advocate or supporter providing consent on behalf of an adult  Parent/guardian providing consent on behalf of child/adolescent client | | | |
| **I am providing consent in order to:** | | | |
| Start services with APMHA *please continue to section A*  Request my information to be transferred to another service *please continue to section B* | | | |
| **Section A: When starting services with APMHA** | | | |
| I agree that information about my health and wellbeing may be collected, used and disclosed to the health provider(s) to whom I am referred.  I agree to de-identified information being collected. I am also aware that this information will **not** identify me will be used for program reporting purposes by APMHA. | | | |
| **Section B: When transferring to or from APMHA services** | | | |
| I agree to my mental health care to be transferred to APMHA HealthCare.  I agree that my care and mental health information will to be transitioned to a new service provider to ensure continuality of my care.  I agree to de-identified information being collected. I am also aware that this information will **not** identify me will be used for program reporting purposes by APMHA. | | | |
| **Opt-out of Audit** | | | |
| APMHA participates in audits for practice standards where clients are interviewed. We also regularly audits client files for quality and safety purposes. Please tick the relevant box if you do not want to participate. | | I do not want to:  have my file used in an audit.  participate in an accreditation audit | |
| **Client name** | **Clients signature** | | **Date** |
|  |  | |  |
| **Parent or guardian name** | **Parent or guardian signature** | | **Date** |
|  |  | |  |
| **Health Professional Declaration** | | | |
| I have discussed the required consent with the client and/or parent/guardian and I am satisfied that the person understands and has provided informed consent to the proposed collection, use and disclosure of personal health information. | | | |
| **Health Professional name** | **Health Professional signature** | | **Date** |
|  |  | |  |