





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 ✕		I understand that if I say yes (or I agree to something) I am giving my consent.
Yes ✓	No ✕		I agree (give my consent) that my provider can collect information about my health, needs, interests and goals
Yes ✓	No ✕		I agree auditors can look at my information when doing an NDIS audit
Yes ✓	No ✕		I understand my funding bodies might need to look at my information for an audit review




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

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: