Information Sharing Consent Form

Name:	CHI/Fwi no:	DOB:

Information about you may be shared with staff in NHS Dumfries and Galloway and Dumfries and Galloway Council to assist us in providing you with services you may need. We may also need to share information with other people/agencies directly involved in your care.

1. I have been given a leaflet about information sharing ☐
I have been given an explanation about information sharing ☐

2. I agree to the following **people/agencies (e.g. GP)** being contacted for information for this assessment

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3. Please tick
I agree to

- **Full information** about me and my ongoing care being shared **across agencies.** ☐
- **Basic details** and information about agencies involved in my care being shared **across agencies** ☐
- **Full information** about me and my ongoing care being shared **only within** ☐

…………………………………………(Name of Service/Team**)**

4. Additional details about sharing my information

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I understand how my information may be shared and that I can update my wishes if I change my mind about any permission granted in this consent form:

Person	**Practitioner**
Signed by:	Signed by:
Name (print):	Name (print):
Date:	Date:
Legal Status (Proxy):	Designation:
Consent valid until:	For office use/reference: