







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 ✗		Photograph
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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:	