[enable] Plan Management

CONSENT TO OBTAIN/ RELEASE INFORMATION

PARTICIPANT NAME: _____

We need to collect some personal and sensitive information from you to provide you with a service. Your information will be collected, maintained, used, shared, stored and disposed of according to our Privacy Policy, available at http://ebldisabilityservices.org.au/information-and-privacy/. (Enable Plan Management is a division of EBL Disability Services Inc ABN 37 305 705 379.)

Your personal and sensitive information is protected by law, including by the Commonwealth Privacy Act 1988.

What personal information will be collected and how will it be used?

Personal and sensitive information may include how to contact you, your health status, your age and your cultural background. However, the information will only be used for the purposes you (or your nominee/advocate) agree to (consent) and according to law. It will be stored securely, protected from inappropriate access and kept only for as long as required.

What if I don't want to provide certain personal information?

Your (or your nominee/advocate) consent to provide personal and sensitive information is voluntary; however, in certain circumstances a failure to provide certain personal information may delay providing a service.

Who will know about my personal information?

Enable Plan Management will not share your personal and sensitive information with any person or organisation without your consent. The exceptions to this are when the disclosure of information is required for law enforcement including but not limited to the NDIA, NDIS Quality and Safeguards Commission, SAPOL, child welfare or to prevent or lessen a serious threat to life, health or safety.

Relevant Organisations

Please list the organisations and/or individuals below that we can contact and share your information with to provide appropriate and timely services to you.

I _____ date of birth ____ / ____ / _____

understand that for the purpose of receiving appropriate and timely services from Enable Plan Management, I consent to its representatives collecting and disclosing information about the above mentioned participant (including personal information and health information) within Enable Plan Management and from/to the organisations and individuals listed below.

Organisations and name of the person appointed to support:

Support Coordinator (name and organisation)	
EBL Disability Services Inc. (SIL, STA & DO)	
Other services/supports:	

☐ I do not consent to share with anyone other than disclosure of information that is required for law enforcement as mentioned on Page One. (Please go straight Signing area on Page Three)

In addition, I agree to the following:

☐ I will advise Enable Plan Management of any changes or additions to the organisations and individuals listed above.

☐ I consent to Enable Plan Management collecting or disclosing my personal or health information from/to other organisations or individuals (other than those described above) where Enable Plan Management reasonably considers:

- a situation requires a rapid response to protect my health and welfare, and it is unreasonable or impracticable to obtain consent from me or the appropriate listed contact, or
- health services from other organisations or individuals are necessary, and Enable Plan Management is unable to contact me or the appropriate listed contact within a reasonable time to seek consent.
- I consent to Enable Plan Management disclosing my personal information where necessary for quality or audit requirements to government agencies, funding bodies and their agents or contractors.

☐ This consent is for the purpose explained to me by Enable Plan Management staff and is valid (ongoing) from the date it is signed, unless I cancel it in writing.

Please note: this form is to be fully completed before someone is asked to sign it (to stop something being added at a later date). Any blank spaces are to be struck out.

Signature of Participant/Nominee/Advocate: _____

If Nominee/Advocate, print name: _____

Relationship to Participant: _____

Date _____/_____/_____

I hereby declare that as the person's nominee/advocate, I can give approval for EBL Disability to obtain/release information as indicated and that this consent will remain until further notice.