BALLYFERMOT LDTF

TREATMENT & REHABILITATION PILOT PROJECT

SHARING OF INFORMATION DOCUMENT

We would like your permission to collect and share information, when necessary, between workers involved in your care plan. We want to do this so we can understand your needs better, provide appropriate supports and avoid asking you for the same information more than once. This information will only be shared on a need to know basis. It might include sharing information with other professionals as agreed with yourself as part of your care plan. **This agreement covers information in your assessment and care plan and is valid for six months, at which time it will need to be signed again as part of your care plan review.**

Your confidentiality is assured except when there is an issue around; child safety; harm to yourself or others or if the courts request a report from a worker.

I agree that appropriate information, relevant to my recovery may be shared with other agencies and with other professionals. This agreement is only valid for 6 months and needs to be renewed after that. I will discuss this with my Key worker if I have any concerns

Signature of service user: _____

Date of signing this agreement: _____

You can change your mind at any time by contacting one of the workers involved in your care. This will be recorded on your file and logged onto this original consent.

Date consent withdrawn: _____

Signature of worker: _____

Date of agreement: 27th June 2011.