Information sheet

Data collection/storage and information sharing about an adult service user

Your Healthcare CIC will collect, process and securely store information about you in an electronic format for the **purpose of providing health or social care**.

Only staff that are involved with your care, or supporting those caring for you, may see details of your clinical record, and may include doctors, nurses, therapists, mental health social workers and some administrative staff.

All staff must abide by a strict code of conduct on security and confidentiality.

Withdrawing consent

You have the right to withdraw consent **at any time**.

To withdraw consent complete a 'Withdrawal of Consent' form.
This form can be obtained by either:

- asking a member of staff
- emailing contact@yourhealthcare.org

The need to share your information

We may share some information with other organisations (e.g. secondary care hospitals, Royal Borough of Kingston) in order to provide good quality care for you.

When considering who may see information about you, Your Healthcare staff follows the principles set out in the General Data Protection Regulations (GDPR) EU 2016/679):

- Staff only share information **with those who need to know** in order to provide good quality care
- Share the **minimum** information necessary to ensure good quality care

All organisations/ agencies/ individuals with whom we share information are required to abide by strict Sharing Information Protocols.

Adult Service User Consent Form
for data collection/storage and information sharing

Service User Name		**NHS Number**	
Date of birth		**Date**	

Service User to complete
Part 1 - I agree to my health information being shared with the following organisations:
Part 2 - I do NOT agree to my information being shared with: Please list any organisations/ agencies or individuals whom you do not want us to share your information with. You do not have to give a reason for this.
If you are satisfied with the above please complete and sign. **Print name:** _____ **Signed:** _____ **Date:** _____

Supervising Professional to complete
Print name: _____ **Profession:** _____ **Signed:** _____ **Date:** _____

REVIEW CONSENT on a regular basis, as agreed with the service user/carer.
Any change to this document requires a new form to be completed to reflect the current wishes of the service user.

If the service user is incapable of giving consent, the health professional responsible may review consent should they feel it is necessary and in the best interest of the service user.