

# consent to share & privacy

## What is this form and why is it important?

Confidentiality is an important part of the relationship you have with the team at headspace Bendigo and it will be one of the first things we discuss with you during your first session with us. Confidentiality at headspace means that anything you say or talk about with a member of our team remains private and won't be passed on to anyone else unless you give us permission.

There may be times when we need to give information about you to other people. For example, if there is a serious risk of you harming yourself or others, if a crime is committed, or a court has a reason to access these records using a subpoena or other court order. In these situations, we will only ever provide the information that needs to be disclosed, only to the people who need to be told, and we will always tell you who we are giving this information to and why.

### What happens with your information at headspace Bendigo?

At headspace Bendigo, we use three Electronic Medical Records (EMR) to store your details and information about your sessions. All staff use an EMR called MasterCare and our GPs, Nurses and Administration also use an EMR called Best Practice. All staff use hAPI (headspace Application Platform Interface). All EMRs are password protected and secured to ensure your information stays private. Staff will only access information that is relevant to their role.

If you would like access to your records, you are able to request this. However, there is a formal process involved that can take some time to be completed and if you are under 18 there may be additional requirements involved. If you would like to find out more about this, please ask a member of the headspace team for more details.

#### How your information helps us provide healthcare services to you:

The information stored at headspace Bendigo is used to provide you with the most appropriate service to meet your need. When you sign this form, you will be giving relevant team members consent to access your information now and in the future. Staff will only access information that is pertinent to their role.

### How your information helps us provide healthcare services to the community:

The information you provide to us is used to evaluate how well headspace Bendigo provides health services to young people in the local area. This helps us understand the needs of the young people who come to headspace and improve our services for everyone.

# How your information is used to evaluate the performance of headspace Bendigo:

All headspace centres are funded by the Australian Department of Health (DOH) through organisations called Primary Health Networks. headspace Bendigo is funded by, and reports to the Murray Primary Health Network (Murray PHN). Headspace Bendigo also provides information to headspace National office for evaluation purposes. The DOH regularly evaluates all services provided by headspace to see where improvements could be made to help young people in Bendigo. The DOH is sent information about the young people accessing our services which has been de-identified. This means we don't send details which could be used to identify you as an individual, such as your name or address.

#### Your rights

Your Welcome Pack contains details of your rights and responsibilities in accessing support and care from headspace Bendigo. As this is a voluntary service, you are free to leave, come back, modify or withdraw the consent listed on this form at any time.

If you would like to change your consent, discuss accessing your records, make a complaint, or provide feedback on the service you have received, please ask to speak to a member of the headspace Bendigo team and we will be happy to assist.

Authorised by: headspace Bendigo Manager Maintained by: headspace Bendigo Manager

Review Date: 13/05/2026

Effective: 03/01/2024 Current Version: 27/06/2025 Page 1 of 2



# consent to share form

□I conse	ent to receiving support from h	eadspace Bendigo, which	may include a		
range of assessments, activities, and services.					
☐I understand that this service is voluntary and that my consent remains while I					
am a current client with headspace Bendigo. □I understand that headspace Bendigo does not provide emergency services, crisis support, or after-hours					
care.					
$\Box$ I understand headspace Bendigo's privacy policy covers the collection, storage, disclosure, and security of					
my information.					
☐I understand that my information will be shared in a formal, multi-disciplinary team discussion, to ensure I receive the most appropriate care.					
leceive the most appropriate care.  ☐I understand my details will remain confidential and securely stored unless there is a serious risk of me					
harming myself or others, a crime is committed, or a valid court order is filed.					
$\Box$ I understand that my de-identified information may be used for research and service improvement /					
evaluation purposes. □I understand my Electronic Medical Record (EMR) may be audited by headspace Bendigo staff for quality					
assurance purposes.					
☐I understand that I will be asked to complete a hAPI survey prior to each session I attend at headspace					
and my clinician may review my responses before my appointment. This information will be used to provide					
me with the best support possible and a de-identified version will be shared with the headspace National Office for use in their service evaluations and/or research.					
☐I understand I can withdraw or change my consent at any time.					
☐I have received a copy of the Welcome Pack and understand the headspace Bendigo rights and					
responsibilities.					
I consent to students on placement participating in my appointment: Yes $\ \square$ No $\ \square$					
Contact Type	Name of Agency/Person	Type of Information	Purpose/s	Contact Details	
	headspace Bendigo	All relevant information	Shared care/referral	5406 1400	
Family member / Next of Kin					
Health Care (GP,					
Psychologist etc) School / School					
Professionals					
Case Managers					
Employer					
If Young Person 15 years old or younger or does not have capacity to consent:					
Parent / Guai	rdian Name:				
Signature: Date:					
□Verbal consent obtained due to telehealth appointment.					
headspace Worker:					
Name:					
Position:					
Signature: Date:					
Conv. Brow	ided to Young Person				
• •	ided to Young Person Share Information form provid	ded to voung person			

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