

Release of Information – Form 1

Please complete this form using a black ballpoint pen

Name of Person Referred: _____

Date of Birth: ____/____/____ (dd/mm/yyyy)

I hereby give consent to Acquired Brain Injury Ireland to obtain information on my clinical, educational and occupational history. I understand that this information may be used to assess the suitability of Acquired Brain Injury Ireland Services to my needs / to tailor services to my needs / in the provision of healthcare services. I understand that ABI Ireland will hold some of my information on a secure electronic database.

I understand that I may revoke this consent at any time by writing to Acquired Brain Injury Ireland. If information has already been released based on my consent, my request to stop the consent will not apply to information already released.

Signature of Person Referred **Date:** ____/____/____ (dd/mm/yyyy)

If the person referred is unable to sign the consent form, it may be signed below on their behalf by a representative.

Signature of Representative **Date:** ____/____/____ (dd/mm/yyyy)

Relationship to Person Referred
(i.e. Next of Kin, Next Friend, Parent or legal guardian)

In line with the Data Protection Act 2003, any information received by or disclosed by ABI Ireland about individuals will only be held with regards to the intended purpose i.e. to assess a referred person's needs in order to identify if and how ABI Ireland can meet their needs. If the person referred is offered a service, the assessment information will remain on the individual's file.

Miscellaneous information will be gathered and used by the organisation to monitor the demand for service; we may also use this to inform organisational development and business priorities.

Release of Information – Form 2

Please complete this form using a black ballpoint pen

Name of Person Referred: _____

Date of Birth: ____/____/____ (dd/mm/yyyy)

I hereby give consent for Acquired Brain Injury Ireland to release reports and information on my rehabilitation and progress to my G.P. and other clinicians involved in my care.

I understand that I may revoke this consent at any time by writing to Acquired Brain Injury Ireland. If information has already been released based on my consent, my request to stop the consent will not apply to information already released.

Signature of Person Referred

Date: ____/____/____ (dd/mm/yyyy)

If the person referred is unable to sign the consent form, it may be signed below on their behalf by a representative.

Signature of Representative

Date: ____/____/____ (dd/mm/yyyy)

Relationship to Person Referred

(i.e. Next of Kin, Next Friend, Parent or legal guardian)

In line with the Data Protection Act 2003, any information received by or disclosed by ABI Ireland about individuals will only be held with regards to the intended purpose i.e. to assess a referred person's needs in order to identify if and how ABI Ireland can meet their needs. If the person referred is offered a service, the assessment information will remain on the individual's file.

Miscellaneous information will be gathered and used by the organisation to monitor the demand for service; we may also use this to inform organisational development and business priorities.