My Permission to Share

Details of how the County Council uses personal information are available on request and can be found in the Adult Services Your Information leaflet that will be given to me with this form.

(PRINT IN BLOCK CAPITALS)

Name: _____ DOB/Gender _____

Address: _____ Telephone: _____

_____ Email: _____

_____ NHS Number: _____

[Found on letters from your GP/hospital]

_____

Post Code: _____ AIS Number: _____

[The County Council provide this]

In signing this form, I am agreeing to my information being shared as set out below.

1. Facilitating my care and/or support

I give my permission for appropriate information about me to be shared between Hampshire County Council, other local authorities, NHS organisations, independent providers, family and friends for the purpose of facilitating and monitoring my care and/or support, unless I tell you not to. This may include assessing my needs, planning my care, providing my care, and monitoring and reviewing my care.

This may also include sharing my information with independent organisations who provide a service to the local authority (for details, see the Your Information leaflet).

Yes to all ☐ **No, see my objections below** ☑

Details of person & relationship / organisation	Comments
Hampshire Health Record (HHR)	Please do not extract & upload any information about me to the HHR

2. Other services and types of support

I consent to my contact details and/or NHS number being used so that I can receive optional follow up services from the local authority or other organisations that may be of benefit to me, such as a health check; a safety check from my local fire service; advice from a voluntary organisation, housing association or district council; and benefits advice from the Department of Work and Pensions.

Yes to all ☐ **No, see my objections below** ☐

Name of organisation	Comments

3. Planning and improving care services

I consent to the local authority and NHS organisations sharing information about me to plan, provide, and improve the care and services provided to everyone, as long as no steps are taken to identify me as an individual.

Yes ☐ **No** ☐

I have the right to change or withdraw my permission to share information about me. I expect the organisations that I notify to hold a record of My Permission to Share, which they will keep updated.
I expect that organisations who wish to share information about me to provide, in appropriate formats, details of:

- how they use personal information
- how I can access information they hold about me, and how to make a request for information about another person
- how I can change My Permission to Share, and who to contact if I have any queries.

The County Council will discuss any concerns I may have about sharing my information in case my refusal to give permission could restrict the services or support they can provide to me.

Email adult.services@hants.gov.uk
Telephone - 0300 555 1386 (Out of Hours - 0300 555 1373)

Signature box (a) for people who have capacity and can sign

I, _____ **consent to my information being shared as set out in this form.** **I have received the Your Information booklet, April 2014, which explains why and how Hampshire County Council shares people's information.**	
Signature:	**Date: / /**
Signed on behalf of Hampshire County Council **Signature:**	**Name:** **Position/Role :**
Date: / /	**Office Address:**

Signature box (b) for people who have capacity but cannot sign

I, (person's representative / Key Worker) _____ **confirm that I am signing under the direction of** **(persons name) _____** **They have received the Your Information booklet, April 2014, which explains why and how Hampshire County Council shares people's information.**	
Signature: ***(Key Worker / person's representative)***	**Date: / /**
Signed on behalf of Hampshire County Council (*if different from above*) **Signature:**	**Name:** **Position/Role :**
Date: / /	**Office Address:**

Appendix 1. People who lack capacity

Section 1. For all people who lack capacity

I *(name of Key Worker)* being a key worker for *(person's name)* , confirm that a Mental Capacity Act assessment has been carried out and state that they do not have capacity to consent to share their personal information.

Section 2. For people who have a Health and Welfare Attorney or a Health and Welfare Deputy

For people who have a Health and Welfare Attorney or a Health and Welfare Deputy who has the authority to consent to sharing of their personal information, then permission to share should be sought from the attorney/deputy and this form should be completed and signed by them.

I (*name of attorney/deputy),* being a Welfare Attorney under a Lasting Power of Attorney dated / / or Welfare Deputy Order dated / / with authority to consent to the sharing of personal information about the person named above, confirm that I consent to relevant information being shared with NHS and social care organisations for the purposes of facilitating their care, providing other support services, and to plan and improve services for them.

Signed:	Date: / /
Name:	Address:
In the presence of :	Office Address:
Signature: *(Adult Services Department Staff Name)*	
I confirm that I have had sight of the original LPA or Welfare Deputy Order and a copy has been taken for the Service User's record. Date: / /	

Where a Health and Welfare Attorney or Deputy has not been appointed, or, where a Health and Welfare Attorney or Deputy has been appointed but they do not have the necessary authority to consent to sharing the person's information, a Permission to Share cannot be completed and any sharing of information must be as a result of a Best Interest Decision, and recorded accordingly. Please complete Section 3 below as appropriate

Section 3. For People Who Lack Capacity to Consent where there is no Welfare Deputy/Attorney with authority

I *(Key Worker name)*, confirm that I have carried out a best interest decision and that it has been decided that it is in *(state person's name)* best interests to share relevant information about them for the purposes of facilitating their care, offering other services and support and to help plan and improve services for them.

Such information as will be shared will be kept to a minimum.

Best Interests decisions attached	**YES**	**NO**
Decision 1	☐	☐
Decision 2	☐	☐
Decision 3	☐	☐
Practitioner signed name:	Dated: / /	
Print Name:		
Address:		

Once completed, send this form to:

Hampshire County Council
Adult Services Department
The Castle
WINCHESTER
SO23 8UQ