



# Non-Clinical Support Consent Form

I, \_\_\_\_\_ hereby give consent for employees of the Mental Illness Fellowship of Queensland (Incorporated as Schizophrenia Fellowship of Queensland) to receive and share information with Doctors, Case Managers, Mental Health Services and other individuals relevant to my support and service delivery as nominated below.

I am aware that this will enable the service to:

- Gain appropriate information to assist the type of support I receive
- Ensure the best possible service plan and delivery

1. 'Global Mark' Independent Accreditation Team – DSQ standards
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Please note that the Fellowship is required to release information about program participants (without identifying you by full name or address) to Disability Services Queensland and to the Australian Institute of Health and Welfare, to enable statistics about disability services and their clients to be compiled.

The information will be kept confidential for a period of 7 years. This information is used for statistical purposes only and will not be used to affect your entitlements or your access to services.

As a program participant of CSTDA-funded services you have the right to access your own files and update or correct information in the CSTDA NMDS collection.

I have been offered independent advocacy services prior to signing this form.

Program Participant: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Mental Health Worker: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**For Office Use Only – 6 monthly review from completion date. New form to be completed, please ensure that the individuals the program participants give consent to be contacted in relation to the non clinical support match those indicated on their program participants contacts from.**  
Next Review Date: \_\_\_\_\_