**Consent Form for Information Sharing in the Transfer of Care for People Experiencing or at Risk of Homelessness**

This form allows the Health Service Executive (HSE) to share your personal information with relevant stakeholders involved in your care as part of the Protocol for the Transfer of Care for People Experiencing Homelessness or at Risk of Homelessness in the Dublin Region. By signing below, you authorize HSE to share information about your health, social, and housing needs with key stakeholders, including the Local Authority/Central Placement Service (CPS), Social Inclusion, key workers, case managers, community health services, and voluntary organisations, in accordance with the HSE National Consent Policy.

**1. Purpose of Consent**

The purpose of sharing your information is to ensure a coordinated approach to your health and social care needs, facilitating your discharge from the hospital, and supporting your transition to appropriate housing and community services.

**2. Who May Seek Consent?**

Only healthcare workers involved in your care, and who have adequate training and knowledge of your treatment, may seek consent to share your information. HSE staff will ensure that you are fully informed about the purpose and nature of information sharing and answer any questions you may have before seeking your consent.

**3. What Information Will Be Shared?**

HSE staff may share relevant information about your health, housing, and support needs with:

* Local Authority/CPS for housing support and placement
* Social Inclusion
* Designated key workers and case managers involved in your ongoing care
* Community health services for medical and support needs
* Voluntary organizations that provide additional resources and assistance

**4. Scope of Consent**

You may specify limits to your consent and decline to share certain types of information. You may also withdraw or adjust your consent at any time by notifying your healthcare provider, and they will document these preferences in your healthcare record.

**5. Documentation and Record-Keeping**

Your consent will be documented in your healthcare record, and a copy of this consent form will be included. This form serves as a record of your consent and the type of information shared under this protocol.

This information will be shared with

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| **List services with whom the data will be shared** (e.g. Local Authority/Central Placement Service (CPS), Social Inclusion, Designated key workers/case managers, Community services including PHN, community integrated care Mental Health Teams, etc.): | **Type of information to be shared** (e.g. Health needs; Housing and accommodation requirements, other support needs, NOK etc.): |
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**6. Validity and Duration of Consent**

Consent may be revisited if there are changes in your condition, treatment needs, or key stakeholders involved in your care. If you wish to update or withdraw consent at any time, please inform your healthcare worker.

By signing below, you acknowledge that:

* You understand the purpose and scope of this consent.
* You have had the opportunity to ask questions and received answers.
* You agree to the sharing of your information as specified in this form.
* You sign consent of your own free will.

**Name of Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Signature of Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Witness Name (if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Signature of Witness (if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_