** Adult Consent Form**

**The University of Queensland ABN 63 942 912 684**

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| --- | --- | --- | --- | --- | --- |
| **Last Name:** | **First Name:** | | | | |
| **Date of Birth:** | **Gender (plea** | **se circle):** | **Female** | **Male** | **Unspecified** |
| **Phone 1:** | **Phone 2:** |  | | | |
| **Email:** | | | | | |
| **Address:** | | | | | |
| **Spouse/Carer/Guardian Name (if applicable):** | | | | | |
| **Spouse/Carer/Guardian Phone:** |  | **Email:** | | | |
| **How did you find out about these services?** | | | | | |
| **My signature (below) indicates that I fully understand and agree to the following conditions and give the following permissions**:   * I hereby grant The University of Queensland (‘**UQ**’) permission to render assessment/therapy/exercise/rehabilitation treatment services to me. * I understand that services rendered in the UQ Virtual Village Nutrition and Exercise Program are provided by students in UQ’s Faculty of Health and Behavioural Sciences under the supervision of qualified Clinicians. * I understand that as students are undertaking placements in the UQ Virtual Village Nutrition and Exercise Program it may be necessary for my clinic file and the information contained therein and other personal information (including mine and that of other specified Spouse/Carer/Guardians) to be shared with other UQ staff, students and third party service providers in relation to my care, the assessment of students and the administration of the UQ Virtual Village Nutrition and Exercise Program and I consent to this. * I understand that staff and students providing services are required to adhere to professional ethical standards and the Information Privacy Principles in the *Information Privacy Act 2009* (Qld). * I have accurately completed a health screening form and will inform the student of any changes that occur to my health throughout the exercise program. * I acknowledge that I am responsible for the consequences of any decisions to accept or reject advice and/or treatment for my care. The program takes no responsibility for exercise undertaken beyond supervised consults. * I consent to UQ using my de-identified information for other teaching purposes and also for research and to share it with third parties involved in such research (such as staff and students of other universities and industry participants). * I consent to UQ staff and students using my information and that of other specified Spouse/Carer/Guardians for the purpose of identifying potential participants for future research projects and for communication in relation to possible participation. I understand this does not in any way oblige me to participate in such research projects.   **Request for permission to use of recording devices for clinical and educational purposes**   * I consent to the UQ Virtual Village Nutrition and Exercise Program making audio and video recordings and taking photos of me during assessment, exercise and treatment sessions for the purpose of providing the services and training the students involved and to them sharing those recordings and photos with staff, students and third party service providers in relation to my care, the assessment of the students and the administration of the UQ Virtual Village Nutrition and Exercise Program in relation to my assessment and treatment.   **Please select: YES NO**    I understand I can withdraw this consent by giving UQ written notice.  **Signature: Date:**  **Office Use: Form received by *(UQ Staff/Student):*** | | | | | |

**Authority to Obtain and Release Information**

I (name) hereby give my consent for the following person(s) and/or service providers to discuss with the health professional and/or students who are involved in providing services to me, information directly relevant to the program of assessment and/or treatment in which I am participating at the UQ Virtual Village Nutrition and Exercise Program.

**PLEASE TICK RELEVANT BOXES AND INCLUDE CONTACT NAME AND DETAILS**



|  |  |  |
| --- | --- | --- |
| **Person** | **Name** | **Contact phone and email** |
| Relative or Friend |  |  |
| General Practitioner |  |  |
| Medical Specialist |  |  |
| Exercise Physiologist/Scientist |  |  |
| Dietitian |  |  |
| Physiotherapist |  |  |
| Occupational Therapist |  |  |
| Audiologist |  |  |
| Speech Pathologist |  |  |
| Psychologist |  |  |

Signature: Date:



# Additions or deletions to this list after the signed date should be initialled and dated by the client.

**Privacy**

Personal information obtained using this authority will not be disclosed to any person or agency without your express consent unless required by law. Your personal information may be disclosed to a health care professional only in relation to the purposes stated above. For more information about your privacy rights, please see our Privacy section on the following webpage: <https://ppl.app.uq.edu.au/content/privacy-management-policy>