Participant Consent Form

Understanding Community Health Care Experiences

- I agree to participate in a conversation regarding my recent health experience with Ballan District Health and Care.
- I understand I can withdraw my comments at any time and do not have to give any reason for withdrawing.
- I also understand that I may be contacted in the future as part of an evaluation of this project. I understand I can opt out at any time.
- I understand that my personal information will remain confidential unless I consent to share my story.
- I agree to have my conversation recorded – YES/NO *(please circle)*
- I agree to be contacted to assist with an evaluation of this project - YES/NO *(please circle)*

Client Information:

Print Name: Date:

Signature: Telephone:

Email address:

If required:
Name of Carer/family member Signature:

Telephone:

Interviewer details:

Cathy Bushell Signature:
Agency Liaison Officer- Service Integration

Central Highlands Primary Care Partnership

Phone: 5332 2943

Email: cathyb@chpcp.org.au

I have informed the above person about this conversation and I am sure they understand the consent of this Participant Consent Form.