**Table 1: Summary of models for consent to use health information**

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
<th>Strengths and weaknesses</th>
<th>Jurisdictions</th>
</tr>
</thead>
</table>
| Full consent | Full explicit consent is required for each use of an individual’s data. In this model, people are asked to consent to each use of personally identifiable information, including audits, quality assurance, reminder notices and research. | • Administratively onerous  
• Expensive  
• May impose unnecessary burdens on consumers | Theoretical            |
| Opt in      | Participants give explicit consent on initial contact with health care program and sign a waiver for the use of information, with suitable assurances of confidentiality. In this model, individuals are registered in the program, provided with information about all the potential uses of the information and asked to sign a form for the use of personal information. There is an option to opt out at any time. | • Consistent with certain interpretations of fair information practices  
• Administration may impose unwelcome burdens on practitioners  
• May have unfavourable cost:benefit ratio  
• Authorization bias | Minnesota              |
| Opt out     | Participants are assumed to want to contribute health information and are given the opportunity to opt out of the program at their request.                                                                 | • Most likely to achieve high coverage rates  
• No burden on practitioners  
• Information about the use of the data is available to consumers  
• Not regarded as consent by consumers | Australia, Iceland, genetic database |}

[Return to text]