Consent Form

Your doctor requires your consent to collect personal information about you. Please read this consent form carefully and sign where indicated below.

Your doctor collects information from you for the primary purpose of providing quality health care. Your practitioner requires you to provide your personal details and a full medical history so that they may properly assess, diagnose, treat and be proactive in your health care needs. This means they will use the information you provide in the following ways:

- Administrative purposes in running their medical practice
- Billing purposes, including compliance with Medical and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside their medical practice. This may occur through referral to other doctors or for medical tests and in reports or results returned to your practitioner following referrals.
- Disclosure to other doctors who work from the practice, locums etc. attached to the practice for the purpose of patient care and teaching. Please let your practitioner know if you do not want your records accessed for these purposes and this will be recorded on your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management, all information in these instances is un-identified. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling Patient Information.

I understand that I am not obliged to provide any information requested of me but failure to do so may compromise the quality of healthcare and treatment given to me.

I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by the doctor and the clinic for the purpose set out above, subject to any limitations on access or disclosure of which I notify the clinic.

Name …… Signed ……

Name of Guardian (for child) …… Signed ……

Date ……

Health Information Collection and Use Consent Form

As a patient your independent medical practitioner will require you to provide the clinic with your personal details and a full medical history, so that your medical practitioner may properly assess, diagnose, treat and be proactive in your health care needs.

Your doctor aims to protect the privacy and secure storage of your health information. You can request a copy of the privacy policy which includes information about the collection, use and disclosure of your health information. Your doctor requires your consent to collect personal information about you and to use the information you provide in the following ways.
Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors who work at the clinic, practice, locums etc. attached to the clinic for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually, information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements e.g., notifiable diseases.
- For reminder correspondence which may be sent to you regarding your health care and management.
- Payment in full is required at the time of the consultation. A full consultation fee will be charged for consults cancelled or not attended.

You can decline to have your health information used in all or some of the ways outlined above but it may influence their ability to manage your health care to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.	☐
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	☐
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.	☐
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.	☐
I consent to the handling of my information by the doctor and the clinic for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	☐
OR	
I am unsure and would like to discuss this further with my doctor before I sign.	☐

Patients Name_____ Date_____/_____/_____

Patient's signature_____

Signed as Guardian for child_____ Name (printed) _____