PRIVACY CONSENT FORM

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Provider No. 201820HB

The privacy laws require that I obtain your consent for the collection, use and disclosure of your personal information. Please read this carefully, and sign where indicated below.

This medical practice collects information from you for the primary purpose of providing quality health care. I require you to provide me with your personal details and a full medical history so that I may properly assess, diagnose and treat your health care needs. This means I will use the information you provide in the following ways:

- Health care purposes
- Administrative purposes in running my medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your health care, including the doctor who referred you, treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals
- Disclosure to third parties for administrative, legal and financial purposes
- Quality assurance activities, which may include discussing clinical matters in strict confidence with other professionals
- Disclosure for research to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to 'opt out' of any involvement

Your Consent

- 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 that my failure to do so may compromise the quality of the health care and treatment given to me
- I am aware of my right to access the information collected about me, except in some circumstances where access might be legitimately and legally withheld. I understand 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 understand that if I have any concerns or questions with the handling of my personal or health information, I can discuss them with you and the concerns will be treated professionally and promptly
- I consent to the handling of my information by this practice for the purposes set out above

Signed: _____

Patient Name: _____

Date: _____/_____/_____

☐ By checking this box you agree that the name or mark provided constitutes your electronic signature and agreement to the terms outlined herein.