

Name: Mrs/Ms/Miss/.....

Address:.....
.....

Telephone (H).....(W).....

DOB.....

Health Fund.....Health Fund No:.....

Medicare No: Patient No: Expiry Date:.....

Dept. Vet Affairs No:.....

Referring Doctor:.....

We require your consent to collect personal information about you.

Please read this information carefully and sign where indicated below.

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

- ° Administrative purposes in running our medical practice.
- ° Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- ° Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice and Hospitals prior to admission for Day Surgery etc. if necessary. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.

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 that my failure to do so might compromise the quality of 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 legitimately be withheld. I understand that 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 this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Signed Date...../...../.....

Patient