

CONSENT FORM

Dear Patient,

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

This 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 medical history so that we may properly assess, diagnose and report findings relating to your medical requirements at this time. This means we will use the information you provide in the following ways:

- Administrative purpose in running our practice
- Billing purposes, including compliance with Medicare and health Insurance Commission requirements
- Disclosure to others involved in your health care, Including treating specialists and doctors outside of this practice. This may occur through referral to other doctors or specialists or for medical tests and in the reports or results returned to us following the referrals
- Disclosure for research and quality assurance 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.

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 I will be given an explanation in these circumstances.

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: