Patient consent for collection of information

Health Information Collection and Use Consent Form

As a patient of the Drs here, they 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.

Drs aim to protect the privacy and secure storage of your health information. You can request a copy of Drs privacy policy, which includes information about the collection, use and disclosure of your health information. Its available on their websites

Drs require 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 their medical practice eg Hotdocs for appointments, other add on software
- 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 may occur though referral to other doctors, or for medical tests and in the reports or results returned to Drs following referrals.
- Disclosure to other doctors here for the purpose of patient care and teaching.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For recalls and reminder letters , emails, sms or phone calls which may be sent to you by the Drs regarding your health care and management.
- For health promotion
- For quality audits
- Complaints management
- Deidentified data given to PHN and others for research and quality improvement and improved patient services purposes
- Uploading to my health record which Drs and you may access
  Only give us contacts we can contact you on and regularly update them each visit

You can decline to have your health information used in all or some of the ways outlined above but it may influence our 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 identified 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 Drs and Drs support staff 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 someone from the medical practice before I sign.	☐

Patient name: _____

Patient / guardian Name: _____

Patient / guardian Signature: _____ Date: / /