PRIVACY INFORMATION AND CONSENT FORM

The law gives you certain privacy rights in relation to information that you give to this Day Hospital. We need your consent to collect personal information about you.
The fact that you have come here implies that you consent to us knowing about your health situation either for a particular event or generally.
This form explains why we need to collect this information, what your rights are over the use we make of the information and how we may disclose it to other medical providers.

The information we may ask you to give us is deeply personal. But not having it will restrict our capacity to provide you with the standard of medical care that you expect.

Please carefully read the following information about privacy issues then sign this form where indicated below. It will go on your file and you may examine it or change it at any time.

The main reason we collect information from you is so we can assess, diagnose and treat your illnesses properly and be pro-active in your health care.

We will also use the information you provide in the following ways:

- Administration of this Day Hospital.
- Compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your health care, including doctors and specialists outside this day Hospital who may become involved in treating you. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals. If necessary, we will discuss this with you.
- Disclosure to others for medical defence purposes if necessary.
- Legislation requirement for disclosure of data to Queensland Health, Federal Health, Australian Bureau of Statistics and your Health Funds and Department of Veteran's Affairs.
- Disclosure for research and quality assurance activities 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.
- To identify Next of Kin.

Please turn over

PATIENT'S ACKNOWLEDGEMENT:

I have read this form and understand why collecting information about me is necessary. 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. I also understand that failure to provide this medical practice with all the information it needs may restrict the practice's ability to provide the quality of health care and treatment that I want.

I am aware that I have the 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 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 purpose set out above, subject to any limitations on access or disclosure about which I notify this practice now or at any future time.

I acknowledge that I have read this form before signing it and that a member of the staff of this practice has at my request clarified any aspects of it that I did not at first understand.

……
Print name

Signature:…….

Date:……