# Privacy Consent Form

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|---|---|---|---|---|---|
| Title: | | Given Name: | | Middle Names: | |
| Surname: | | Known As: | | Date of Birth: | |
| Residential Address: | | Suburb/ Town: | | Postcode: | |
| Postal Address: (if different) | | Suburb/ Town: | | Postcode: | |
| Home Phone: | | Work Phone: | | Mobile: | |
| Email Address: | | | | | |
| Medicare Number: | __ __ __ __-__ __ __ __ __-__ | Patient's individual number on Medicare: | _ | Expiry: | _ _/_ _ _ _ |
| HCC/ Pension Number: | | Expiry: | | DVA Number: | |
| Private Health Fund | | | | Member Number | |

| | | | |
|---|---|---|---|
| Account Holder: *(if patient under 18)* | | Account Holder's Date of Birth: | |
| Account Holder's Medicare Number: | __ __ __ __-__ __ __ __ __-__ | Account Holder's individual number on Medicare: | _ |

| | | |
|---|---|---|
| Emergency Contact | First Name: | Home Phone: |
| | Surname: | Work Phone: |
| | Relationship: | Mobile: |
| Alternative Contact | Name: | Numbers: |

I give my permission for Health Quest Medical Clinic to collect, use and disclose my personal information as outlined on the back of this document. I understand that I am able to withdraw my consent as to the use and disclosure of my personal information except when legal obligations must be met. I am aware that I am entitled to access my own health records as outlined in the Practice Privacy Policy except where access would be denied as per the Privacy Act 1988 guidelines.

Yes ☐ No ☐

I give my permission for Health Quest Medical Clinic to place me in the appointment reminder service.

SMS ☐ **OR** Phone ☐

I give my permission to leave a contact message with the family member above or a third party, whose name appears above, if I am not available.

Yes ☐ No ☐

I give my permission to leave my test results with the family member above or a third party, whose name appears above, if I am not available.

Yes ☐ No ☐

I give my permission for Health Quest Medical Clinic to communicate with me by electronic means eg email.

Yes ☐ No ☐

"I have read the disclosures on the next page of this form."

Signed:_____ Date:_____

**HEALTH QUEST INTEGRATIVE CLINIC ("the practice")**

**Patient Consent to Collect and Disclose Information.**

The Privacy Act 1988 requires medical practitioners to obtain consent from you, the patient, to collect, use and disclose your personal information. This information is needed to properly treat and advise you, and may be collected by the medical practitioner or our practice staff.

Information collected, used and disclosed may include full medical history, family medical history, genetic and ethnicity details.

Normally we would collect the information directly from you but there may be occasions when we will need to obtain the information from others, such as:

1. Other general medical practitioners and specialists.
2. Other health professionals such as physiotherapists, psychologists, psychiatrists, pharmacists, nurses, dentists, etc.
3. Hospital and Day Surgery facilities.

In an emergency we may need to obtain personal information from relatives or other sources *if* we are unable to obtain your express prior consent.

**Use and Disclosure**

The practice will only use and disclose your personal and health information for the following reasons:

1. Account keeping and billing purposes.
2. Referral to a medical specialist or another health care provider.

2A. Provision of a prescription in digital form to a pharmacy to which you have taken a prescription.

3. Referral to a hospital for treatment and advice.
4. Advice on treatment options.
5. Day to day management of this practice, including disclosure to practice health professionals, administrative staff, and information technology staff and contractors for the purposes of maintaining and improving the practice's systems.
6. To meet our obligations of notification to our insurers and medical defence organisation.
7. To prevent or lessen a serious threat to an individual's life, health or safety.
8. Where legally required to do so, such as providing records to a court, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases.

**Access to your records**

You are entitled to access your own health records at any time convenient to both yourself and the practice.

**Consent to be included in the Practice reminder system**

In order to provide continuity of care, and in the interests of preventative medical management the practice maintains a reminder system. Your consent is needed to be a participant in the recall system, and you have the right to refuse if you wish.

**Disclosure of Financial Interest**

The practitioner you see has or may have a direct or indirect financial interest in a pharmaceutical manufacturer or wholesaler of medications which the practitioner may prescribe or in a provider of pathology or imaging services to which the practitioner may refer you. The practitioner will prescribe or refer on the basis of his or her professional judgement but you are not obliged to follow those recommendations in sourcing the medications or services. If you wish to consider alternative providers, please discuss this with your practitioner so he or she can explain the basis of the professional judgement made.

**Security**

We take reasonable steps, both physically and electronically, to ensure your personal information is protected from misuse and loss and from unauthorized access, modification or disclosure. We may hold your information in either electronic or hard copy form. Personal information is destroyed or de-identified when no longer needed.

As the internet inherently insecure, we cannot provide any assurance regarding the security of electronic transmission of information.

Our websites may contain links to other websites or third parties. We make no representations or warranties in relation to the privacy practice of any third party website and we are not responsible for the privacy policies or content of any third party website.