**Patient Health Information Consent Form**

Our practice values the privacy and security of your personal information collected to provide you with the best care.

Personal information is managed in line with the *Privacy Act 1988* and the *Australian Privacy Principles.*

For more information about our Privacy Policy please ask a receptionist or review our webpage.

**What we collect and store:**

* name, date of birth, address, contact details, next of kin, gender
* medical information including medical history, medications, allergies and reactions, immunisations, social history, risk factors, family history
* Medicare / DVA/ Concession card
* information from other people who are providing care (e.g. specialists) and;
* any other information to meet your health needs.

**Your medical and personal information may be used and shared to support your healthcare needs for the following reasons:**

* other healthcare people such as our staff, treating doctors, specialists and allied health professionals visiting the practice or external
* to run our practice (e.g. Medicare billing, accreditation companies, I.T people)
* when it is required by law (e.g. notifiable diseases, court order)
* students (such as medical/nursing/allied health) in this practice
* other people (e.g. your guardian, power of attorney, carer) and;
* updating national registers such as immunisation and cancer screening.

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**Your contact details may be used to remind you of appointments and/or the need to return for follow up with our clinic (examples: health checks, follow up on results, immunisations)**

* An SMS/ letter or telephone call to remind you of appointments/ or need to return for follow up with our clinic

**I AGREE for my information to be used for reminders *(please circle appropriate answer)***

***YES NO***

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**Your de-identified information is used for, or by:**

* Quality Improvement activities at the practice
* Accreditation
* students and staff to participate in medical training/teaching.
* Gold Coast Primary Health Network to inform local health needs and services and;
* research purposes.

**I AGREE for my de-identified information to be used for the above reasons *(please circle appropriate answer)***

***YES NO***

**\*either choice will not affect how we care for you**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give my permission for my personal contact

*(Please print name)*

and health information to be collected, used and disclosed as indicated as per my choices above.

I can change my mind at any time. I will tell the practice if this happens.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If signing on behalf of the patient, print your name below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your relationship to Patient (e.g. Mother, Father, Guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PRACTICE USE ONLY:***

**ID Check:** 🞎 Photo ID (or equivalent) 🞎 Medicare Card 🞎 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witnessed by Staff Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_