

## SPRINGWOOD GROUP GENERAL PRACTICE

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

This medical 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 a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Disclosure to other doctors in the practice and locums for the purpose of patient care. Please let us know if you do not want your records accessed for this purpose and will note your record accordingly.
- 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.

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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 and if I have not attended, my records will be destroyed by incineration after 7 years.

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 the health care and treatment given to me.

I am aware of my right to access 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 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 purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Signed: ..... (patient) Date: .....

Should you have any concerns regarding a breach of your privacy, please contact our Practice Manager or your Doctor. If you wish to take the matter further and feel that you need to discuss the matter outside the surgery, the Health Rights Commission may be contacted on 3234 0333.