The Lismore Clinic
Your partner in good health

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CONSENT FOR THE COLLECTION, USE AND RELEASE OF PERSONAL & MEDICAL INFORMATION IN ACCORDANCE WITH PROFESSIONAL STANDARDS REQUIREMENT

Patient Privacy is important to The Lismore Clinic. We respect your rights and ensure all personal and health information remains private and confidential. Your health information refers to information pertaining to your health, medical history, and past and future medical care.

The Lismore Clinic is bound by the *Privacy Act 1988 and The Privacy Amendment Act 2012, The Australian Privacy Principles and Health Records and information Privacy Act 2001.*

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

The Lismore Clinic 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 and treat illnesses and be pro-active in your health care. Both our practice staff and the medical practitioners may participate in the collection of this information. In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your prior express consent. We will also 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. (e.g. Pathology & Radiology providers, immunisation registers, specialist or community/allied health referrals, etc).
- Disclosure to other doctors in the practice, Locums, Medical Students and by Registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we 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.
- Where legally required to do so, such as producing records to court, mandatory reporting of child abuse.

I (full name) : _____ Date of Birth: / / ,

Of (address) : _____ Suburb: _____ ,

Phone: _____ ,

Please turn over…

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.

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 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 I request access to information about me, the practice will be entitled to charge me fees to cover:

- Time spent by administrative staff to provide access
- Time necessarily spent by a medical practitioner to provide access at the practitioner's ordinary sessional rate and
- For photocopying and other disbursements at cost.

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

I hereby authorise The Lismore Clinic to obtain my medical details from, or supply information to, my previous GP/referred specialist/other healthcare and diagnostic providers involved in my ongoing care. I am aware this practice stores its medical records electronically and that secure systems are used to allow efficient communication between this practice and other medical practices.

Signature of Patient: _____ Date: / / ,

Or

Signature of Parent/Attorney/Guardian: _____ Date: / /
,

Next of Kin / Contact person: _____ ,

Phone: _____ Mobile: _____ ,

Relationship to patient: _____ ,

Consent for SMS appointment reminders: Yes / No **(please circle)** Mobile: _____ ,

Consent to discuss appointments: Yes / No **(please circle)**

Consent to discuss results: Yes / No **(please circle)**

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