BERRI MEDICAL CLINIC

29 McGilton Road, BERRI SA 5343

Ph: (08) 8582 2855 Fax: (08) 8582 3413

www.berrimedical.com.au

ABN: 61 820 028 450

Quality Practice Accreditation

Patient Health Information Consent Form

As a patient of our medical practice 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.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.	☐
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	☐
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. 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 the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	☐
OR	
I am unsure and would like to discuss this further with someone from the medical practice before I sign.	☐

Patient's name: …… **Patient's signature:** ……..…..… **Date:**……

Name of Guardian: …….. **Signed as Guardian for child:** ……..

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The Privacy Act requires your consent for the following:

A) if I am unable to be contacted for results of tests, change of appointment time etc, then a message can be left on the phone number you have left for our records.

B) I consent for medical information to be collected and provided to other health providers:

- for the provision of ongoing medical care
- Health care prevention
- Accreditation and Quality assurance
- Billing and collection of professional fees
- Teaching and research

C) I consent for:

Full Name:……Date of Birth:……...
Relationship to Patient:……..
Phone:……..……

Full Name:…… Date of Birth:……
Relationship to Patient:……....
Phone:……..……

Full Name:……...Date of Birth:……
Relationship to Patient:…….
Phone:……..……

Full Name:……...Date of Birth:……
Relationship to Patient:……..…
Phone:……..……

To collect prescriptions, referral letters etc. on my behalf.

Patient's name: …… Date: ……

Patient's signature: …… Patient Date of Birth:……