THE DOCTORS. HOPE ISLAND

HEALTH INFORMATION COLLECTION CONSENT FORM

As a patient of our practice, we require you to provide us with your personal details and a fill Medical History so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We strive to protect and securely store your personal information. You can request a copy of our Privacy Policy or refer to it on our website (www.thedrshopeisland.au) which outlines details as to our standards for 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 to our clinic in the following ways;

- *Administrative purposes in running our medical practice.*
- *Billing purposes, including compliance with Medicare and Health Insurance Commission requests.*
- *Disclosure to others involved in your healthcare, including treating doctors & specialists outside this practice. This may occur through referrals 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 purposes of patient care.*
- *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 reminders which may be sent to you regarding your health care and management*

You may decline to have your health information used in all or some ways outlined above but it may influence our ability to manage your health care.

I hereby confirm by ticking the corresponding boxes that; I have read the information above and understand the reasons why my information must be collected.	☐
I understand 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 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 purposes set out above, subject to Any limitations on access or disclosure of which I notify the practice.	☐
I am unsure and would like to discuss this further with someone from the practice before I sign	☐

PATIENT/ GUARDIAN SIGNATURE _____

PATIENT FULL NAME _____ Date / /2025

Signed as Guardian for Child: **NAME**_____**RELATIONSHIP**_____