WYPERFELD MEDICAL CLINIC

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PRIVACY AGREEMENT AND PATIENT CONSENT

To enable ongoing care and quality improvement in this practice, and in keeping with the privacy Act 1988 and National Privacy principles, we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restriction to this consent.

Your personal health information will only be used for the purposes for which it was collected or as otherwise permitted by law and we respect your right to determine how your personal health information is used or disclosed.

The information we collect may be collected by a number of different methods such as medical test results, notes from consultations. Medicare and health insurance details, data collected from observations and conversations with you and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/guardian) are consenting that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- Follow up reminder/recall noticed for treatment and preventive healthcare.
- For accounting procedures and the collection of professional fees.
- The diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided.
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GPs and other professionally trained and qualified person e.g. General Practice Managers or Medicare Local.
- For legal related disclosure as required by a court of law.
- For the purpose of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training / teaching using only de-identified information.
- For disease notification as required by law.
- For use when seeking treatment by other doctors, nursing and allied health in this practice and outside it.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

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 treatment given to me.

I have read the information above and understand the reasons why my information must be collected.

I am aware of my right to access the information collected about me except in some circumstances where access might legitimately be withhold. I understand I will be given an explanation in these circumstances.

I give my permission for my personal health information to be collected, used and disclosed and described above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice.

Patient Name:……**Signature:** ……

Date: …… **Person filled form:** ……