North Coast Surgical Suite

Suite 14, Level 4
St Vincent's Specialist Medical Centre
20 Dalley Street
LISMORE NSW 2480
Phone 02 66218277
Fax 02 66216669

PATIENT CONSENT TO COLLECT & DISCLOSE INFORMATION

PRIVACY ACT: The Privacy Act 1988 and The National Privacy Principles
The Privacy Act 1988 requires medical practitioners to obtain consent from their patients to collection, use and disclosure of that patient's personal information.

Collection

This means we will collect information that is necessary to properly advise and treat you. Such necessary information may include:

- Full medical history
- Family medical history
- Ethnicity
- Contact details
- Medicare / private health fund details
- Genetic information
- Billing and account details

The information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources, but not limited to, for example:

- Other medical practitioners, such as former GPs and specialists
- Other health care providers such as physiotherapist, occupational therapists, psychologists, pharmacists, dentists, nurses, radiologists pathologists, and
- Hospitals and Day Surgery Units

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.

Use & Disclosure

With your consent, the practice staff will use and disclose your information for purposes such as:

- Account keeping and billing purposes
- Referral to another medical practitioner or health care provider
- Sending specimens such as blood samples or biopsies for analysis
- Referral to hospital for treatment and/or advice
- Advice on treatment options
- The management of our practice
- Quality assurance, practice accreditation and complaint handling
- To meet our obligations of notification to our medical defense organisations or insurers
- To prevent of reasons a serious threat to an individual's life, health or safety
- Where legally required to do so, such as producing records to court, mandatory reporting of child abuse or the notification of certain communicable diseases.

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Storage & Transmission

With your consent, this practice will store the information it collects, in formats including but not limited to hard copy and/or electronically and that transmission of such information is conducted by, but not limited to post, fax and email.

Consent

I provide my consent for:

Dr D J Bills / Dr S L M Butchers / Dr H C M Foster / Dr R A Simon

to collect, use and disclose my personal information as outlined above.

I understand that I may withdraw my consent as to use and disclosure of my personal information (except when legal obligations must be met).

PATIENT NAME: _____

Patient Date of Birth: ____ / ____ / ____

Patient Address: _____

_____

PATIENT SIGNATURE: _____

AND / OR

SIGNATURE OF PATIENT GUARDIAN / POWER OF ATTORNEY:

_____

WITNESSED:
Per Medical Practitioner: _____

DATE: ____ / ____ / ____