

PATIENT PRIVACY INFORMATION & CONSENT TO OBTAIN MEDICAL INFORMATION

The law gives you certain privacy rights in relation to information that you give to this medical practice. Mildura Cardiology realizes the importance of maintaining your personal information confidentially. We do need your consent to collect personal information about you. The fact that you have come here indicates that you consent to us knowing about your health situation. On occasion we will need to collect information from other sources about you, for example, other doctors, x-ray and pathology services. We need your consent to have this information released.

The information we have will be used in accordance with the policies and standards set out in the AMA Privacy Health Record 2014, which we can obtain for you if you wish to read it.

PLEASE READ THE FOLLOWING POINTS CAREFULLY BEFORE YOU SIGN THIS FORM BELOW:

We also use the information we have about you in the following ways:

- Administration purposes in running our medical practice.
- Billing purposes including Medicare, Private health funds, Veteran Affairs, TAC, WorkCare. Concession card details including HCC, Pension Card and Seniors Card for appropriate discount.
- Disclosure to others involved in your health care. This may occur through referral to other doctors if needed.
- Disclosure to other doctors in the practice to assist in your medical management.
- Disclosure for research and audits to improve individual and community health care and practice management (your full name, addresses and phone numbers will not be used for this purpose). You will be informed if such activities are being conducted and asked for specific consent.

PATIENT'S ACKNOWLEDGEMENT

- I have read this form and understand why collecting information about me is necessary.
- I am also aware that this practice has a privacy policy on handling patient information.
- I am aware that I have the right to access the information collected about me, except in some circumstances where access might be legitimately withheld.
- I also understand that I will be given an explanation regarding these circumstances.
- I acknowledge that I have read this form before signing it, and that a member of this practice, at my request, has clarified any aspects.

Signature:

Date:

AUTHORITY TO OBTAIN MEDICAL INFORMATION

I,

Date of Birth authorise the release of my health information as requested to Mildura Cardiology.

Signature: Date:

Witness Signature: Witness Name: