HEALTH INFORMATION CONSENT FORM

MEDICAL PRACTICE: NIGHT DOCTOR PTY LTD, PO BOX 387, SOUTH FREMANTLE, WA 6162

At Night Doctor, we are required to collect and store your personal details and a full medical history to provide you with safe and effective care. To do so, we require your consent or the consent of a legal guardian. Please read this consent form carefully, and sign where indicated below.

We require your consent to collect, store and use the information that you provide for the following purposes:

- Administrative purposes in running our medical practice.
- Medicare billing purposes.
- Disclosure to others involved in your healthcare such as your GP, paramedics and hospital staff. We send your visit notes and results of investigations to your GP.
- Disclosure to other doctors in the practice for the purpose of ongoing care and teaching.
- For research and quality assurance activities to improve individual and community healthcare and practice management. For this activity we remove all information that can identify you.
- To comply with any legislative or regulatory requirements. For example, we are required to notify some diseases to the health department.
- For letters, which may be sent to you regarding your healthcare and management.

You have the right to access the information collected about you, except in rare circumstances where access may be legitimately withheld. You will be given an explanation in these circumstances. You can decline to have your health information used in the ways outlined above, however this may influence our ability to manage your healthcare and provide the best health outcome for you.

A detailed explanation about the information we collect, use and securely store, is detailed in our Privacy Policy, which we encourage you to read. A copy can be found on our website (www.nightdr.com.au) or you can request a paper copy from our Doctors during your visit or by calling our reception on: 1300 644 483. I have read the above information 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 healthcare 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 purpose other than set out above, my consent will be obtained.
- I consent to the handling of my information by Night Doctor for the purpose set out above.

PATIENT'S NAME: _____

PATIENT'S SIGNATURE: _____

OR

LEGAL GUARDIAN'S NAME: _____

LEGAL GUARDIAN'S SIGNATURE: _____

DATE: ___/___/_____