North Nowra **Medical Practice**

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## PERSONAL HEALTH INFORMATION

*Welcome to North Nowra Medical Practice*

*To enable ongoing care and total quality improvement within 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 of restrictions 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 and examples may include: 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/parent/guardian) are consenting, that on obtaining your Personal Health Information it may be used or disclosed for the following purposes:*

- *Follow-up reminder/recall notices 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 allied health care providers to ensure quality care is provided*
- *Accreditation and Quality Assurance Activities, which are conducted by professionally trained non-treating General Practitioners and other professionally trained and qualified persons (e.g. Practice Managers.)*
- *For legal-related disclosure as required by a court of law (e.g. court order, subpoena)*
- *For the purposes 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. (e.g. infectious diseases)*
- *For use when seeking treatment by other doctors in this practice.*

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

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*I, _____give my permission for my Personal Health Information to be collected, used and disclosed as 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 rescind, alter or restrict my consent at any time by notifying this practice in writing.*

*Patient Name: (Please Print)_____*

*Signature:_____Date:_____*

*If not Patient signing your name (Please Print)_____*

*Your relationship to patient (e.g. Mother, Father, Guardian)_____*

*Witnessed by: (Staff Signature)_____*