MEDICAL
HAEMATOLOGY
SERVICES

Privacy Concent and Health Information Form

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, includingcomplience with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care and/or claim. This may include treating doctors, specialists, allied health care personnel outside this medical practice and any third party that is involved with your case. This may occur through referral to other doctors or for medical tests and in the reports or results returned to us following the referrals.
- Emergancy situations whereby medical officers or hospitals require access to patient notes for treatment purposes.

I have read the information above and understood the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information. 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 and treatment given to me. I am aware of my right to access the information collected about me, except in some cirumstances. I understand that if my information is to be used for any other purposes other than set out above, my consent will be obtained. I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Patient's name _____ **Date of Birth** _____

Address _____

Phone (Home) _____ **Phone (Mobile)** _____

Occupation _____

Medicare No. _____ **Expiry** _____

Pension No. _____ **Expiry** _____

D.V.A No. _____ **Expiry** _____

Health Fund _____ **Card No.** _____

Person responsible for Account _____

Next of Kin: Name _____ **Relationship** _____

Phone _____

General Practitioner: Name _____

Address _____

Phone _____ **Fax** _____

Signture _____ **Date** _____

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