ALKIMOS BEACH
MEDICAL CENTRE

DR SAM HANNA DR ESSAM BOTROS
DR GEMMA CAINE DR RICHARD MARSTON

HEALTH INFORMATION COLLECTION, USE AND DISCLOSURE: PATIENT CONSENT FORM

This General Practice collects information from you for the primary purpose of providing quality healthcare. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your healthcare.

This is the Privacy Policy for Alkimos Beach Medical Centre. The Privacy Act 1988 requires Medical Practitioners to obtain consent from their patient's personal information. This Policy outlines how we will collect, store and use your medical information to provide you with the best possible medical care. Your personal 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 information is used and disclosed.

COLLECTION: Collection of Patient information will include:

- Full Medical History
- Social History
- Genetic Information
- Medicare/Private Health Fund Details
- Billing/Account details

Family Medical History
Ethnicity
Contact Details
Next of Kin details

The information will normally be collected directly from you. There may be occasions when we need to obtain information from other sources, for example:

- Specialists, other Medical Practitioners, Gp's
- Other healthcare providers such as physiotherapists, psychologists, pharmacists, dentists and nurses
- Both our Practice Staff and Medical Practitioner may participate in the collection of this information.
- In emergency situations, we need to collect personal information from relatives, or other sources when we are unable to obtain your prior express consent.
- Hospitals and Day Surgery Units

USE AND DISCLOSURE: The information may be provided to people such as:

- Your referring doctor pertaining to your medical management
- To prevent or lessen a serious threat to an individual's life, health or safety
- Where State or Federal Law requires (i.e notifiable disease or court orders)
- Referrals to other doctors, specialist
- Sending of specimens, such as blood samples
- Referral to a hospital or day surgery units for treatment
- Medicare or your Private Health Insurance
- My Medical Indemnity organisation if I am obligated to do this.
- Billing purposes including compliance with Medicare.
- Follow-up of results/recall noticesfor treatment and preventative healthcare.
- De-identified data will be collected by Primary Health Alliance for the purposes of accreditation and quality improvement activities, to improve individual and community healthcare and practice management.

- For Legal related disclosure as required by a COURT OF LAW.
- To allow medical students and staff to participate in medical training/teaching using only DE-IDENTIFIED information.
- To comply with any legislative or regulatory requirement, e.g notifiable disease directorate.
- When seeking treatment from another Gp at this surgery.

Access can be denied where;

- The information relates to anticipated or actual legal proceedings and you would not be entitled to access the information in those proceedings.
- Your request is frivolous
- It is in the interest of National Security
- To provide access would create a serious threat to life or health
- The access would unreasonable impact on the privacy of another

ANONIMITY: On request, patients have a right to request that they be treated anonymously where this is practical and lawful. At all times, we are required to ensure your details are treated with the utmost of confidentiality and privacy.

SENSITIVE INFORMATION: Sensitive information will only be collected with the patients consent or where it is required by law or in special specified circumstances.

CONSENT

I, ____ have read and understand the reasons why my information must be collected, and the purposes for which it may be used and disclosed.

I,____ give permission for my personal information to be collected, used and disclosed as described above, including contact via sms to my mobile. I understand that only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at anytime and in writing to the practice manager.

Patient's Name: ______________________________________

Signature:____ Date:__________________

Or Signed on behalf of my child: __________________________

PRACTICE USE ONLY

Witnessed by: (staff signature):____

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