

# BORDER PHYSICIANS GROUP PATIENT CONSENT

Border Physicians Group will conduct its services in accordance with the Australian Privacy Principles and will ensure your confidential information is respected.

We require your consent to collect personal information about you. Please read this information carefully and sign below where indicated.

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, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we will note your record accordingly.
- Images and/or video may be taken of your procedure in hospital at the time of your surgery. This is for the purpose of providing quality patient care, education and/or research only.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement.
- Provide information to the Multi-Disciplinary Team Meetings to facilitate your care

Your information will be kept securely and confidentially in electronic format within this practice. Your information will be kept for the minimum term required by law.

Health and personal Information due for disposal, is shredded by an approved provider, complying with relevant privacy laws and regulations.

- I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling the 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 understand that I may request access to my health records. This must be in writing and I must provide proof of my identity prior to the request being authorised. Charges may be incurred with this request. Your request will be handled within 45 days of the letter of request being received and/or within 7 days of your payment being received.
- I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.
- I understand in the event where an overdue account is referred to a collection agency and/or law firm, I will be liable for all costs which would be incurred as if the debt is collected in full, including legal costs.
- 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 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_