Care Gynaecology
Dr Trixie Rasmuson

Privacy Information & Consent Form

The law gives you certain privacy rights in relation to information that you give to this medical practice. We need your consent to collect personal information about you. The fact that you will attending a consultation at Care Gynaecology implies that you consent to us knowing about your health situation, either for a particular event or generally. This form explains your rights in relation to the use of the information and how we may disclose it to other medical service providers.

The information we may ask you to give us is deeply personal. However, not having it will restrict our capacity to provide you with the standard of medical care that you expect.

Please carefully read the following information about privacy issues then sign this form where indicated below. It will go on your file and you may examine it or change it at any time.

The main reason we collect information from you is so we can assess, diagnose and treat your illnesses properly and be pro-active in your health care. We will also use the information you provide in the following ways:

- Administration of this medical practice.
- Billing, including compliance with Medicare and legislative requirements.
- Disclosure to others involved in your care, including doctors and specialists outside this practice who may become involved in treating you. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals. If necessary, we will discuss this with you.
- Disclosure to others for medical defence purposes if necessary.
- Disclosure to other doctors, locums, registrars and nurses within the practice for the purpose of patient care.

Patient's Acknowledgement:

I have read this form and understand why collecting my information about me is necessary. 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. I also understand that failure to provide this medical practice with all the information it needs may restrict the practice's ability to provide the quality of health care and treatment that I want.

I am aware that I have the right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

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 authorise Care Gynaecology to communicate with me using the details provided upon patient registration.

I acknowledge that I have read this form before signing it and that a member of the staff of this practice has at my request clarified any aspects of it that I did not at first understand.

Patient Signature:…….. Date: ……

Please Print Name:……. DOB:……