PATIENT CONSENT FORM

The Inglewood Medical Centre requires your consent to collect personal information about you. Please read the consent form carefully, tick the applicable boxes and sign where indicated.

Our Medical Centre collects such information for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history to allow us to properly assess, diagnose, treat and advise on all your health care needs. Please place a tick in the following boxes if you consent for this information to be used by the Practice in the following ways:

- I give permission for my personal health information to be used for administrative purposes to assist in the running of the Inglewood Medical Centre, including disclosure to others involving my healthcare, such as Doctors, Specialists within and outside this Practice. This may occur through referral to other Doctors, or for medical tests and in the reports or results returned to my doctor following referrals.

- I give my consent for disclosure for research and quality assurance activities to improve individual, community health care and Practice Management. This may occur when the Practice incorporates patient health records into de-identifiable patient information to transfer to a third party, normally used for quality improvement projects.

- I give my consent to be part of the Practice’s National, State and Territory Reminder Systems.

- I give consent to the presence of a third party to be present during my consultation. This may include a Nurse, Medical Student, Family Member or a friend, Centrelink or Workcover representative.

Patient Name and Signature: __________________________________________
________________________________________Date_________

Third Party – Name and Signature: __________________________________________
________________________________________Date_________

Thank you