ADELAIDE SKIN & EYE CENTRE / ADELAIDE SURGICENTRE

Patient Privacy Information - Patients Rights and Responsibilities

The National Privacy Principles in the Privacy Act set out how this practice should collect, use, keep secure and disclose personal information. The principles give you the right to know what information we hold about you & the right to correct that information if it is wrong.

What information may be collected? To provide you with quality, ongoing health care, this practice will need to collect information about you. This will include your personal, medical and family health information including medical treatment and associated medical or pathology reports. Your attendance at this practice, together with this information and your signature on this form, is taken as consent to the collection of this information.

How will this information be used? Your information will be used in the normal course of managing your healthcare and will include referrals to additional specialists & allied health providers, which may be prepared & transferred electronically. In addition, access may be required as part of our ongoing professional, clinical and quality assurance programmes. With your consent information and photographs may be used for research or teaching purposes. Patients should be aware that there are some instances where we are legally bound to disclose some of your personal information such as mandatory reporting to the Skin Cancer Registry.

Your access You have a right to see or obtain a copy of the information we hold about you. To do so you will need to make a written request to the doctor concerned. A fee will be associated with processing this request which is not claimable from Medicare.

Security Your medical records will be stored safely and securely at all times. Unauthorised access to information concerning your care will not be permitted.

Your Rights & Responsibilities Are you aware of your rights and responsibilities? Please ask us for a brochure.

Complaints It is important to us that we meet all your expectations in managing your health. Please do not hesitate to discuss any concerns, questions or complaints about any issues with your doctor or any staff member.

Mr / Miss / Ms / Mrs / Dr Patient Surname Given Name
Parent Name / Contact Person D.O.B. of Parent (for patients under 17) / /
Date of Birth / / Country of Birth Occupation
Address
Suburb Post Code
Telephone Home Work
Mobile Email
Medicare No. _ _ _ _ _ _ _ _ _ _ Ref No. _ Expiry Date /
Pension / Concession No. Expiry Date /
DVA Card No. Gold □ White □
Private Hospital Insurance Yes □ No □ Fund Name Membership No.
Name and Address of your GP
Have you seen any of the doctors in this practice previously No □ Yes □ (if yes, when, where)
Why did you choose this practice? Referred by Doctor □ Friend □ Family □ Reputation □ Internet Search □ Convenient location □ White Pages □ Yellow Pages □ SA Life □ Other_____

Please note that this Practice does not Bulk Bill & full settlement of the account will be required at time of service. If you anticipate a problem with payment, please speak to the reception staff prior to your appointment.

I permit the practitioner who rendered the services the authority to electronically lodge the Medicare claim on my behalf.

I give permission for Adelaide Skin & Eye Centre / Adelaide Surgicentre staff to contact me by telephone and, if necessary, leave a message. I have read the Patient Privacy Information and agree to the collection and use of information regarding my care as a patient of the Adelaide Skin & Eye Centre / Adelaide Surgicentre.

_____ **Patients Signature** **Date / /**