RACGP
Royal Australian College *of* General Practitioners

Practice information collection statement

Name of practice _____

requires your consent to collect personal information about you.

Name of 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 pro-active 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 Australia;
- ☐ Disclosure to others involved in your health care, including treating doctors and specialists outside this practice. This may occur through referral to other doctors, or for medical tests and in the reports returned to us following the referrals;
- ☐ Disclosure to other doctors including locums and to allied health workers and nurses who work in the practice;
- ☐ Disclosure to visiting teachers and accreditation surveyors for the purposes of teaching and accreditation of the practice; and/or
- ☐ Disclosures for research and quality assurance activities to improve individual and community health care and practice management. This information will be de-identified.

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 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 am aware of my 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.

By completing the section below and providing a signature, I consent to the handling of my information by this practice for the purposes set out above, subject to any limitation on access of disclosure that I notify the practice of.

If my consultation is conducted via telehealth, my doctor will ask for my verbal approval and it will be noted in my medical record, along with the name of the GP or medical educator that is present.

Patient name

_____

Patient signature _____ Date _____

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