Consent to Collection of Personal Information- Coastwide Eye Surgery

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 assist, diagnose and treat your eye condition and be pro-active in your eye care. We will also use the information you provide in the following ways:

- Administrative purposes in running our practice;
- Billing purposes, including compliance with Medicare, Health Insurance Commission requirements or Department of Veterans' affairs (whichever is applicable);
- Any appropriate body, if required by law to do so;
- In emergency situations, any person or body deemed necessary;
- Outstanding debts greater than 3 months are sent to our Debt Recovery Agent;
- Disclosure to others involved in your health care, including treating doctors and other specialists and health service providers outside this organisation;
- Disclosure to other doctors in the practice, Principal & Associate Doctors and by Registrars attached to the practice for the purpose of teaching;
- Disclosure to appropriate bodies in relation to quality assessments and quality assurance, clinical auditing and research to improve individual and community health care and practice management.

Please read the below statements:

- I have read the information above and understand the reasons why my information must be collected.
- I am aware that my Personal Information is obtained in many ways including by telephone and facsimile; by mail; by email; via our website at www.coastwideeyesurgery.com.au; in person and from third parties such as referring practitioners, other health care providers and family members in an emergency.
- 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 the practice's main form of communication with me, my referring practitioner and all other health practitioners nominated by me is via mail, email, telephone, facsimile (efax) and My Health Record. I consent to receive communication via email.
- Email address: ____
- I understand that if I own a mobile, I will receive SMS phone reminders of my upcoming appointment via my nominated mobile number.
- I understand I can opt out of email and SMS communication by contacting the practice by telephone or in person.
- I understand this practice uses electronic prescribing requiring use of my email or mobile number.
- I understand this practice uses My Health Record and my doctor or authorised employee may view and/or upload clinical information to my record. I understand I can manage access to My Health Record or 'Opt out' via my MyGov account.
- I am aware that this practice has a privacy policy which I can access by requesting a copy at reception or via the practice website at www.coastwideeyesurgery.com.au.
- I am aware of the importance of keeping my personal details up to date and agree to notify the practice of changes to my personal information as soon as possible by contacting reception via telephone or in person.
- I consent to the handling of my information by this organisation for the purposes set out above, subject to any limitations on access or disclosure that I notify the organisation of.

If you do not consent to any aspect of this form, please discuss this with a receptionist before signing this consent form.

Patient Name: ____ Signature: _____________________________________

Guardian/ Carer Name: _______________________________ Signature: _____________________________________

Date: ______/______/__________