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 other involved in your health care, including treating doctors and other specialists 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. Please let us know if you do not want your records accessed for this purpose and we will note your record accordingly;
- 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.

I have read the information above and understand the reasons why my information must be collected. 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 also aware that this practice has a privacy policy which contains information about accessing and seeking correction of personal information, privacy complaints handling process and whether the practice is likely to disclose personal information to overseas recipients.

I am aware of my rights to access the information collected about me, except in circumstances where access might be legitimately withheld. I understand I will be given an explanation in these circumstances. I understand that if I request access to information about me, the practice will be entitled to charge fees to cover time and administrative costs which may not be covered by a Medicare rebate.

I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained.

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:

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Signed_____ Date _____

Print name: _____