Patient Surname:
Given Names:
DOB:
Occupation**:**
Mobile:
Work:
Home:
Address:
Email:
Medicare**:**
Medicare No: **Expiry:**
Private Fund**:**
Fund Number**:**
Referring Dr**:**
GP:
Allergies:
Partner's Surname:
Given name**:**
DOB**: 00/00/00**
Occupation**:**
Mobile**:**
Work:
Medicare:
Medicare No: Expiry:
Private Fund:
Fund Number:

Dr Shane Higgins 5 February 2018

Privacy Consent

We require your consent to collect personal information about you. Please read this informaiton carefully and sign where indicated below.

This medial 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 to enable us to properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running this medical practice.
- Billing purposes, including compliance with Health Insurance commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside of this medical practice. This may occur through referral to other doctors or for medical tests, and in reports or results returned following referrals.
- Disclosure to doctors performing locum sessions within this practice.

If you have any questions in relation to any of the above matters, please raise these with Dr Higgins.

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 in regard to handling patient information.

I understand that I am not obligated to provide information requested of me, but that my failure to do so might compromise the quality of health care and treatment administered.

I am aware of my right to access information collected about me, except in some circumstances where access might legitimately be withheld. I understand that 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.

I consent to the handling of my information by Dr Shane R Higgins for the purposes set out, subject to any limitations on access or disclosure that I have given notification of.

Name:

Signed:_____

Witness:_____

Signed:_____

Date

_____