



## PATIENT DETAILS

Please return this form to reception once completed  
 admin@gsspecialistcentre.com

First name (as listed on Medicare Card)											
Surname						Middle name					
Preferred name						Title		Date of birth / /			
Residential address											
Suburb						State			Postcode		
Home phone						Work phone					
Mobile						Email					
Name of GP						Practice					
Medicare number											-
Medicare card expiry (bottom right corner) /											
Private Health Fund						Membership number					

Dept of Veterans Affairs number											
DVA card colour WHITE / GOLD						DVA card expiry /					
Concession card number											
Concession card type						Concession card expiry /					
Is this treatment related to a Worker's Compensation claim? YES / NO											
If yes, please ask administration team for Workers Compensation form											
Is this treatment related to a MVA or Criminal Insurance claim? YES / NO											
If yes, name of insurer						Claim number					

Next of kin											
Relationship to patient						Phone					

Person responsible for accounts (if not patient) <input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN <input type="checkbox"/> OTHER											
Name											
Address						Suburb					
State			Postcode			Phone					

**Please read, sign and date consent information on reverse before returning this form to GSSC reception.**

## **PATIENT CONSENT TO COLLECTION, DISCLOSURE AND ACCESS OF PERSONAL INFORMATION**

The Privacy Act 1988 requires medical practitioners to obtain consent from each patient to collect, use and disclose their personal information and to acknowledge the patient's rights to access the personal information held by the practitioner.

### **Collection**

Great Southern Specialist Centre (GSSC) will collect information that is necessary to properly advise and treat you. Such necessary information may include your full medical history, family medical history, contact details, Medicare details, private health fund details, genetic information, billing and account details.

The information will normally be collected directly from you but there may be occasions when we need to obtain information from other sources. Examples are:

- Other medical practitioners (e.g. GP's, specialists, hospitals and day surgery units).
- Other health care providers (e.g. physiotherapists, occupational therapists, psychologists, pharmacies, dentists)

### **Use and Disclosure**

With your consent, GSSC staff will use and disclose your information for purposes such as:

- Referrals to another medical practitioner, hospital or health care provider.
- Advice on treatment options.
- To meet our notification obligations to our medical defence organisations.
- Sending specimens for analysis.
- Quality assurance, practice accreditation and complaint handling.
- Account keeping and billing.
- To prevent a serious threat to an individual's life, health and safety.
- Where legally required to do so such as producing records to court, mandatory reporting of child abuse or notification of diagnosis of certain communicable disease.

### **Access**

You are entitled to access your own health records at any time convenient to both you and GSSC staff. In certain circumstances we may deny access where:

- To provide access would create a threat to health or life.
- There is legal impediment to access.
- The access would unreasonably impact on the privacy of another.
- In the interest of national security.

We ask that where possible you make any request in writing. We may impose a charge for photocopying or for staff time involved in processing your request. Where you dispute the accuracy we will take all steps to record all of your corrections and place them with your file but we will not erase the original records.

**I consent to Great Southern Specialist Centre collecting, using and disclosing my personal information as outlined and I understand that:**

- **I am entitled to access my own health records except where access may be denied as outlined above.**
- **I may withdraw my consent except when legal obligations must be met.**

**By signing this form I also give permission for personal information to be handed to a third party should I default on payment of my account.**

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_