CAROLINE TAN
ADROIT NEUROSURGERY

Privacy Information and Consent Form

In the process of your consulting Dr Tan, her practice will collect and hold information about you that can be of a highly sensitive nature but not having it may adversely affect her capacity to provide you with the highest standard of medical care. Dr Tan's practice will take all possible and reasonable steps to store and handle this information in a manner that complies with the Victorian Health Records Act 2001, the Commonwealth Privacy Act 1988, as well as the National Privacy Principles. Please carefully read the following information about privacy issues then sign this form where indicated below. It will go on your file and you may examine it or change it at any time.

The main reason Dr Tan collects information from you is so she can assess, diagnose and treat your illness properly and be pro-active in your health care. The other reasons are as follows:

- Administration of this medical practice and compliance with quality assurance and professional accreditation bodies
- Disclosure to organisations concerned with the financial aspects of your care, including your health insurance fund and the Health Insurance Commission (Medicare) for billing purposes .
- Disclosure to enable recording on medical registries (eg. cervical artificial disc registry).
- Disclosure to others who may become involved in your health care, including doctors and specialists outside this practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Conducting research
- Education of other health care workers.

PATIENT ACKNOWLEDGEMENT

I have read this form and understand why collecting information about me is necessary, 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. I also understand that failure to provide this medical practice with all the information it needs may restrict the practice's ability to provide the quality of health care and treatment that I want.

I am aware that I have the 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 purpose other than set out above, my written permission will be sought first.

I acknowledge that I have read this form before signing it, and that I have been given adequate opportunity to obtain clarification of any aspects of it that I did not at first understand.

Signed: …….. Dated: ……..…

Name (*please print*): ……..…