NEW PATIENT INFORMATION FORM

COLLECTION & DISCLOSURE OF PATIENT INFORMATION

The Privacy Act of 1988 requires all health practitioners to obtain consent from their patients to collect, use and disclose patients' information.

SA Heart collects your personal information and medical history for the purpose of providing quality cardiac care and so that we may properly assess, diagnose, treat and be proactive in your health care needs.

Disclosure and collection may also be required for administrative purposes in running our medical practice including Medicare, DVA, 3rd party transcription and non-medical information for debt collection if applicable.

For further information visit privacy.gov.au. SA Heart's Privacy Policy is available at saheart.com.au

PATIENT CONSENT

- ○ I consent to the disclosure to and collection from medical/specialist practitioners, allied health practitioners, institutions and hospitals that may require information about my medical history in order to assess/treat the particular condition for which I have consulted the medical/specialist practitioner.
- ○ I consent to disclosure and collection that may also be required for administrative purposes as listed above.
- ○ In emergencies, I consent to SA Heart collecting information from my relatives or friends.
- ○ I am aware that this practice has a privacy policy on handling patient information.
- ○ I acknowledge that I have read this form and understand why collecting information about me is necessary. Before signing this form a member of this practice, at my request, has clarified any aspects as needed.

Patient/Guardian Signature: _____ Date: _____ / _____ / _____

AUTHORITY TO OBTAIN MEDICAL INFORMATION

I, _____

authorise the release of my health information as requested to SA Heart.

Patient/Guardian Signature: _____ Date: _____ / _____ / _____

Witness Signature: _____ Witness Name: _____

AUTHORITY TO RELEASE MEDICAL INFORMATION VIA EMAIL

I authorise SA Heart to release my medical information via electronic mail (email) to my email and/or the email of my family member/carer detailed above, and as necessary, any health practitioner involved in my treatment.

I am aware that SA Heart does not have encrypted email software and cannot guarantee that information transmitted via email will not be intercepted by other parties. By signing this form, I agree to not hold SA Heart or its employees responsible for any breach of confidentiality that may occur by someone else accessing the information contained in any emails sent to or from SA Heart regarding my personal health information.

I understand that reasonable means will be used to protect the security and confidentiality of the email. All concerns to and from me regarding my personal health information will be a part of my medical record and can be viewed by SA Heart doctors and support staff. My email will not be forwarded outside the office without my consent or as required by law.

This release may be revoked at any time by written notice and is valid until such revocation is received by SA Heart.

Patient/Guardian Signature:_____ Date: _____ / _____ / _____

OFFICE USE ONLY **Patient ID #:** _____ **Registered by:** _____ **Date:** _____ / _____ / _____

Submit form