PRIVACY STATEMENT AND FINANCIAL CONSENT

Dear patient

Your doctor will make independent decisions to optimise your clinical outcome. We value your privacy. All information about you, held at this practise, is kept in the strictest confidence. With the introduction of the privacy amendment {private sector} Act 2000 in December 2001, we remain committed to protecting your privacy and are now requesting your express consent for the use and disclosure of your personal health information. In the course of your healthcare, access to your personal health information is necessary to continue the high standard of service you have come to expect from us. Access to this information may be required directly or indirectly by other health care providers such as pathology service, pharmacists, specialists and health care facilities such as hospitals, disease monitoring agencies and Medicare.

Your personal health information will not be sold by this practise to marketing companies and cannot be used for the purpose of promoting non-health related products or services.

I consent to the disclosure of my personal health information by doctors practicing in Morten Bay Women's Health facility to other health care providers directly or indirectly involved in my personal healthcare or Medicare treatment.

FINANCIAL CONSENT

I have been advised of the estimated costs in respect of proposed medical services. I accept responsibility for payment of this account, including [if applicable] a nominated insurer does not pay the anticipated rebate.

For uninsured patients in whom their care is been transferred to Redcliffe Public Hospital , I understand that all Public system rules will be applied such as my queue in the waiting list and the possibility that my procedure may be carried out by another consultant or a Registrar on training.

EXAMINATION CONSENT

I consent to the necessary general/gynaecological examination by Dr Morris or other practising doctors at Morten Bay Women's health.

PERSONAL DECLARATION **I have read and understood the information provided above**

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Patient/Parent/Guardian Signature Print name of patient /Parent/Guardian

Date __ __ / __ __ / __ __ __ __