JOHN PARRY MEDICAL CENTRE

Please update your personal information below and sign the privacy consent form to give to reception on arrival

SURNAME: **FIRST NAME:** **MIDDLE NAME:** **M/F:**
DATE OF BIRTH: **COUNTRY OF BIRTH:** **CULTURE:**

POSTAL ADDRESS:

EMAIL ADDRESS:

TELEPHONE: **H:** **M:** **W:**

MARITAL STATUS: - Single - De Facto - Same Sex Partner
- Married -Separated - Divorced -Widowed

MEDICARE: **M/C REF:** **EXPIRY DATE:**

PRIVATE HEALTH FUND: **MEMBERSHIP NUMBER:**

CONCESSION CARD NUMBER: **CONCESSION EXPIRY:**

OCCUPATION:

ALLERGIES:

HEALTH CONDITIONS (Please list)

MEDICATION LIST:

EMERGENCY CONTACT NAME: **CONTACT NUMBER:**

ACCOUNT HOLDER NAME: **PHONE:**
EMAIL: **DOB:**

I **CONFIRM THE ABOVE INFORMATION TO BE CORRECT**

Signed ____________________________ **Date:**

Parent Privacy Consent Form

Yours and your childs **Personal Health Information** may need to be disclosed for the following reasons:

- Communicating relevant information with other treating doctors, specialists or allied health professionals.
- Follow up reminder / recall notices and state reminder systems (eg. cervical screening - pap smears reminders or familiar cancer registries).
- State registers (eg. Immunisation data)
- Accounting / Medicare / Health Insurance procedures.
- Quality Assurance activities such as accreditation.
- For disease notification as required by law (e.g. infectious diseases).
- For use by any of our doctors/nurses/allied health professionals when consulting with you.
- For legal related disclosure as required by a court of law (E.g. subpoena, court order, suspected child abuse).
- For research purposes (de-identified, meaning you are not able to be identified from the information given).

This Practice is committed to maintaining the confidentiality of your Personal Health Information. It is the policy of this practice to maintain the security of Personal health Information at all times and to ensure that it is only available to authorised members of staff and to comply with the Privacy Act.

Please ask a Staff member if you wish to view our full Privacy Policy

I have been made aware by John Parry Medical Centre of their Privacy Policy, in accordance with freedom of information act 1992. By signing this form I understand & consent to my personal information & medical records being collected, used and disclosed in accordance with, and in no other manner contrary to this document.

On behalf of my Son/Daughter Date of Birth

Signed: ______________________________ Date:

Student Privacy Consent Form

Your **Personal Health Information** may need to be disclosed for the following reasons:

- Communicating relevant information with other treating doctors, specialists or allied health professionals.
- Follow up reminder / recall notices and state reminder systems (eg. cervical screening - pap smears reminders or familiar cancer registries).
- State registers (eg. Immunisation data)
- Accounting / Medicare / Health Insurance procedures.
- Quality Assurance activities such as accreditation.
- For disease notification as required by law (e.g. infectious diseases).
- For use by any of our doctors/nurses/allied health professionals when consulting with you.
- For legal related disclosure as required by a court of law (E.g. subpoena, court order, suspected child abuse).
- Electronic Communications Policy and associated risks
- For research purposes (de-identified, meaning you are not able to be identified from the information given).

This Practice is committed to maintaining the confidentiality of your Personal Health Information. It is the policy of this practice to maintain the security of Personal health Information at all times and to ensure that it is only available to authorised members of staff and to comply with the Privacy Act and Electronic Communications Policy.

Please ask a Staff member if you wish to view our full Privacy Policy and/or Electronic communications Policy

I have been made aware by John Parry Medical Centre of their Privacy Policy, in accordance with freedom of information act 1992. By signing this form I understand & consent to my personal information & medical records being collected, used and disclosed in accordance with, and in no other manner contrary to this document.

Signed: ______________________________ Date:

DOB: