**CHILD / PATIENT DETAILS:**

**Surname:-** ................................................................... **First Name:-** ...............................................**M / F**

**Date of Birth:-** / / **Preferred name:** ..................................................

**Address:-** .....................................................................................................................................................................

**Suburb:** ....................................................................  **Postcode:-**  .................................

**Postal Address if different:** ............................................................................... ..................................

**Does your child have any allergies? If so, please discuss with your doctor.**

**PARENT DETAILS / EMERGENCY CONTACT:**

**Surname:-** ............................................................................. **First Name:-** ..................................................**M / F**

**Date of Birth:-** / / **Preferred name:** .....................................................

**Day Time Phone:-** …………………………………… **Mobile:-** …………………………………… **Wk:-** ……………………………

**Do you consent to receiving SMS reminders of your appointment? Y / N**

**Email address:-** …………………………………………………………………………………………………………………………………………………………

**Medicare No.** …………………………………………………………… **Ref # next to your child’s name:-** ……………

**Exp. Date ………………………………………………. Ref # next to your name**: ……………

**Are you:**

🞏 Aboriginal 🞏 Torres Strait Islander 🞏 Non Indigenous

To assist us in providing your child with the highest standard of care, please let the practice know your cultural background and/or language.

Cultural Background: …………………………………………….. Child’s Country of Birth………………………………………………………..

Language spoken at home: …………………………………………………………………..

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you find out about our surgery?**

**🞏** Word of Mouth 🞏 White/Yellow Pages 🞏 Family/Friends

🞏 Drive / Walked past 🞏 Brochure 🞏 Sydney’s Child

🞏 Other (please specify)………………….............................................................

In accordance with the *Privacy Act (1988),* all information collected in this practice is treated as “sensitive information”. To protect your privacy, this practice operates in accordance with the Act. Selected information may be disclosed to various other health services involved in supporting your health care management, (e.g. Pathology )

**CONSENT**

**🞏 I consent to the use of my child’s personal health information by The Children’s Doctor and other health providers involved in their medical treatment and health care.**

**Signature:- ……………………………………………… Date:- …….. /…….. /………..**

Health Information Collection and Use
Consent Form

**The Children’s Doctor – 129 Wrights Road Castle Hill**

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

* Administrative purposes in running our medical practice.
* Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
* Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
* Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
* For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to “opt out” of any involvement.
* To comply with any legislative or regulatory requirements e.g. notifiable diseases.
* For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

|  |  |
| --- | --- |
| I have read the information above and understand the reasons why my information must be collected. | [ ]  |
| I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me. | [ ]  |
| I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances. | [ ]  |
| I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained. | [ ]  |
| I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice. | [ ]  |
| **OR** |
| I am unsure and would like to discuss this further with someone from the medical practice before I sign. | [ ]  |

Patient name: …………………………………… Date: ………………

Patient/Guardian signature: ……………………………

**Name:** (printed) ……………………………………