

LAKESIDE SQUARE MEDICAL CENTRE

Dr Sally Mc Donald
Dr Leonora Anderson
Dr Jacinda Stork

Dr Jenny Watt
Dr Fahim Shahbaz
Dr Didi Zhao

Dr Tania Siddiqui
Dr Mohammed Mostofa

CONSENT FORM

We require your consent to collect personal information about you. Please read this consent form carefully and sign where indicated below.

This medical practice collects information from you for the primary purpose of providing quality health care. 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 pro-active in your health care needs. This means we will use the information you provide us in the following ways.

- **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 through the 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. Please let us know if you do not want your records accessed for these purposes, and we note in your record accordingly.**
- **Disclosure for research and quality assurance activities to improve individual and community health care and practice management, all information in these instances is un-identified. You will be informed when such activities are being conducted and given the opportunity to “opt out” of any involvement.**

I have read the information above and understand the reasons why any information must be collected. I am also aware that this practice has a privacy policy on handling information.

I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of healthcare and treatment given to me.

I understand that if any 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 purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Signed.....

D.O.B...../...../.....

Name.....

Date.....

Signed as Guardian of child (Childs Name).....