

# Form B

**COMPLETE BOTH SIDES OF THIS FORM AND RETURN TO RECEPTION OF BUILDING 15 PRIOR TO YOUR APPOINTMENT**

**UNIVERSITY HEALTH SERVICE (U.H.S)**  
**CONSENT FOR THE COLLECTION OF PERSONAL INFORMATION**

The U.H.S conducts medical practices on each of the campuses. We collect information from you for the primary purpose of providing quality health care. We need to record your personal details and a full medical history so that we may properly assess, diagnose and treat you.

Please read this information carefully, and if you are in agreement, sign where indicated below.

It is possible that you may not be in full agreement and this needs to be discussed with the attending practitioner.

Your information will also be used 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 health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- De-identified data is collated for future planning and statistical purposes.
- De-identified data is collected for participation in clinical audits that are part of the Commonwealth Programs in General Practice

The UHS is an accredited general medical practice. Every three years a Commonwealth appointed medically qualified auditor will inspect a very small number of medical records for quality of medical record maintenance. You can object to your record being eligible for this process.

Accredited medical practices are required to operate systems for the recall of people with abnormal results and the routine reminder of people for health maintenance reasons. These recall and reminder notices will be sent to the last stated address.

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

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

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify.

I notify the UHS of the following limitations of my information:

.....  
.....

Signed ..... Date .....

Patient

Personal Details are to be completed overpage

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PLEASE PRINT**

Family Name: \_\_\_\_\_

Given Names: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Title: Mr/ Mrs/ Miss/Ms/ Dr (please Circle One) Date of Birth: \_\_\_\_\_

**SEMESTER ADDRESS** \_\_\_\_\_

\_\_\_\_\_ Post Code \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

Are you of Aboriginal or Torres Strait Islander origin? Yes / No

Country of Origin (optional) -----

## **AUSTRALIAN RESIDENTS:**

Medicare No: \_\_\_\_\_ Ref No: \_\_\_\_\_ Exp Date: \_\_\_\_\_

(The Ref No is the number beside your name on the card)

Health Care Card : \_\_\_\_\_ Exp Date: \_\_\_\_\_

Pension Card : \_\_\_\_\_ DVA No: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Private Health Insurance: \_\_\_\_\_

## **OVERSEAS STUDENTS:**

OSHC/ Worldcare / Medibank Private / IMAN /Other No: \_\_\_\_\_ Exp Date: \_\_\_\_\_

(Please Circle One)

## **ALL PATIENTS TO COMPLETE**

Student / Staff / Visitor (please circle one) ID Number: \_\_\_\_\_

Faculty / Department: \_\_\_\_\_

### **Emergency Contact Person in Melbourne:**

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_