YarraMedical

Office Use

Staff Initial:

The Hive
Shop 25 The Hive Shopping Centre,
313 Victoria Street, Abbotsford, Vic, 3067
T: (03) 9027 6262 F: (03) 9421 3514

Richmond
Unit 1, 486 Victoria Street
Richmond, Vic, 3121
T: (03) 9428 6200 F: (03) 9421 3514

Patient Consent For Practice Communications

Please read this carefully prior to signing

The purpose of this form is to inform you and seek your consent to the use and disclosure of your personal information (including health information) in regards to our reminders and notifications systems within our practice.

This general practice is committed to providing our patients with quality health care. As part of our commitment, we have implemented technology solutions to enable communications with our patients via SMS.

In keeping with our obligations under Privacy Act 1988 (Cth) and Australian Privacy Principles and under State and Territory health records legislation, we wish to inform you of the purposes for which we may use your personal information and how we may use and disclose your personal information (including health information). Please refer to our privacy policy or privacy statement on our website for more information generally on the management of personal information (including health information) by this general practice.

In addition to other communications we may send you from time to time, we may send the following types of communications:

1. ***appointment reminders** – notifications to you to remind you of upcoming appointment dates with the practice as well as allowing you to confirm your appointment;*
2. ***clinical reminders** - notifications to you to remind you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures, immunisations due;*
3. ***clinical communications** - communications to you about your clinical care at the practice such as returned pathology results or clinical messages from the medical practitioner; and*

As part of the provision of health care services to you, we will send you appointment reminders, clinical reminders and clinical communications from time to time. We may also send you health awareness information, if you have consented to receive such communications below. We may use third party service providers (which may be located outside of this State or Territory) and disclose your personal information (including health information) to them, to assist us in sending you the above communications.

To the extent practicable, we will send you communications via your preferred contact method indicated below. However, you acknowledge that we may contact you using any of your contact details that you may provide to us from time to time as we consider appropriate.

Acknowledgements and Consent

I acknowledge and agree that, in the course of providing health care services to me, the general practice may need to use and disclose my personal information (including any health information) as set out in this form.

I wish to receive health awareness communications in relation to general health care information and heath care services provided by this practice. This includes notifications about changes to clinic opening hours and information about health care services provided by the practice.

I hereby specifically consent to the use of my personal information (including any health information) by this general practice to assess the types of health awareness communication it sends me and specifically consent to receive such health awareness communications.

PLEASE TICK ONE BOX AND SIGN →

YES	NO	
☐ I Consent	☐ I do not consent	Signature: ________________

Please note: Our preferred method of communication Is SMS. Please advise reception if you prefer an alternate method of communisation.

I acknowledge that the practice will use contact details provided by me (as updated by me from time to time) to communicate with me. To the extent that the mobile number I have provided to this general practice is utilised by more than one patient, I understand and consent that all SMS and phone communications will be directed to that number.

Please complete and sign below if you understand and agree to the acknowledgements and consent set out above.

First Name and Surname ______________________ Date of Birth ____________

Parent/Guardian Name (if Patient is under 16) ______________________

Signature: ______________________ Date: ____________