Brisbane Child Neurology

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Patient Consent Form

Due to Federal Privacy Legislation, our medical practice requires your consent to collect personal information associated with your child's health care. Please read this information carefully and sign where indicated below.

My child's medical and family history is needed to provide accurate medical diagnosis, appropriate treatment and to be proactive in his/her health care needs. To ensure quality and continuity of patient care, child's health information and patient details form may need to be shared with other health care providers and administrators from time to time. There may be occasions when disclosure of information is required for medicolegal purposes.

Therefore, before engaging the professional services of specialists from BCN, you are required to give your consent to all the following areas. Should you require further information regarding the Privacy Act, additional reading is available from reception.

I _____Parent/Guardian of _____

(Please print your name) (Please print your child's name)

Consent to the following in the collection of personal information regarding my child's health care and associated administrative purposes.

- Collection of personal information included on patient detail form for administrative purposes in running our medical practice.
- Use of correspondence regarding my child's personal and health details to other health care providers and administrators which, from time to time, may include some but not all of the following i.e. radiologists, pathologists, referring general practitioners, specialists outside this medical practice and public or private hospitals.
- Billing purposes including compliance with Medicare, Health Insurance Commission, Workers Compensation, Veterans Affairs requirements and the collection of fees.

I have read the information above and understand the reason why my child's information must be collected and I am also aware that this practice has a privacy policy on handling information. I understand that I am not obligated to provide any information requested of my child, but that my failure to do so might compromise the quality of health care and treatment given to him/her. Request for additional copies of medical correspondence will be provided with an appropriate administration charge for forwarding. A cost estimate can be provided on request.

I consent to the handling of my child's information by this practice for the purpose set out above. I consent to be contacted via □ SMS or □ email for administrative purposes.

Signature Date