Dr Jennifer Harmer

CONSULTANT PHYSICIAN & RHEUMATOLOGIST

PATIENT AUTHORITY/ CONSENT FORM

Your personal information is used to assist with your diagnosis and treatment, as well as for accurate personal identification and communication. Specifically, the information is used for the following purposes:

1. Disclosure of information to other health professionals involved in your health care, including your general practitioner, specialists, allied health professionals and providers of medical investigations.
2. Accounting and administrative purposes, and to comply with medical and Health Insurance Commission requirements.
3. Quality assurance with this practise.

MR MRS MISS MS MAST OTHER: (Please circle)

SURNAME:

FIRST NAME: **SECOND INITIAL:**

PREFFERED NAME:

ADDRESS:

POSTCODE:

DATE OF BIRTH:

TELEPHONE: (H) **(W)**

(M)

EMAIL:

MEDICARE NO: **NO. LEFT OF NAME:** **EXPIRY DATE: /**

PENSION/ DVA/ HEALTH CARE CARD (Please circle)

IF YES, NUMBER: **EXPIRY DATE: / /**

REFERRING DOCTOR:

ADDRESS:

POSTCODE:

PHONE NUMBER:

CONSENT:

I have read the above statement and I give my consent to the use of my personal information in the above circumstances. I recognise that I have the right to withhold any information but this may compromise my medical care. I consent that my personal detail may be used to retrieve medical information, including reports and results from medical facilities including hospitals, pathology providers, radiology providers etc. outside this medical practise. I am aware that I can request that a specific health professional does not have access to my personal information. I consent for this practise to obtain my Medicare number if required for billing purposes.

ALL FEES ARE DUE AND PAYABLE AT THE TIME OF CONSULTATION

SIGNATURE:_____**DATE**:_____