Consent – Collection of health information and use

The University of Canberra Medical & Counselling Centre respects your right to privacy and we are mindful that the information that you provide to us **is personal and private**. As a patient or client of this service, 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 proactive in your physical & mental health care needs.

We aim to protect your privacy and ensure the secure storage of your health information. No information about you, including the fact that you have visited the Medical & Counselling Centre will be released to anyone outside of the Centre without your **written permission** except in certain circumstances where we are required to do so by the law (**legal related disclosure).** You can request a copy of our **Privacy Policy**, which includes information about the collection, use and disclosure of your health information as well as how to access your health information.

We require your consent to collect personal information about you, and to use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare, OSHC &/or Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors, psychologists and other allied health professionals and specialists outside this medical practice. This may occur though the referral to other doctors, allied health professionals, or for medical tests.
- Disclosure to other doctors, registered nurses, medical students, psychologists etc. in the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Information that does not identify you (de-identified) is used, however in the event that information that may identify you be required, you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For clinical reminder or recall letters which may be sent to you regarding your health care and management.
- For **legal related disclosure** as requested by a court of law (eg. Subpoena, court order, suspected child abuse or non-accidental physical injury, or in circumstances where we have cause to be seriously concerned for your safety or that of anyone else).

You can decline to have your health information used in all or some of the ways outlined above, but it may influence our ability to manage your health care. If you have any concerns about the above, or wish to restrict access to your personal health information please discuss this with your doctor or psychologist at the time of your consultation.

Tick or cross the box to indicate your agreement with the statement.

I have read the information above and understand the reasons why my information must be collected.	
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld; I will be given an explanation in these circumstances.	
I understand that if my information is to be used for any purpose other than reasons set out above, my consent will be obtained.	
I understand that UCMCC is using a dictation AI software application "Lyrebird Scribe" which allows my clinician to provide comprehensive clinical documentation whilst at the same time providing greater focus on the patient/client. Consent to use this tool will be requested. Any concerns can be discussed with your clinician.	
I consent to the handling of my information by this practice for the purpose set out above, subject to any limitations on access or disclosure of which I will notify this practice.	
OR	
I am unsure of the above, and would like to discuss this further with a member of staff from this Centre.	

Patient's name: (printed) ……**Date of Birth:** ……..

Patient's signature: …… **Date:**……..…..

If patient is a CHILD, to be signed by the parent or guardian of the child: ……

Name of above signature: (printed) …… **Relationship:** ……..