HERVEY BAY surgical hospital

CONSENT FOR THE COLLECTION, USE & DISCLOSURE OF PERSONAL INFORMATION

Affix Patient Label Here

Surname:.....

Given Names:.....

Date of Birth: ...../...../.....

If you DO NOT want us to use or disclose your personal information in any of these ways, please tick the box in the column to show you do not give consent

NOTE: If there is no response by you against an item, it will be taken to mean that you agree with that use.

Use of Personal Information

	NO
1. To train and educate professional staff	☐
2. For health and medical research projects we undertake solely or in conjunction with related Research organisations and external research organisations with which we collaborate or partner ***You will not be identified in any research publication***	☐
3. To assist in the development of service delivery and planning facilities	☐

Disclosure of Personal Information

	NO
4. To or from other medical practitioners, hospitals or health service providers to assist in any current or future treatments that relate to the condition for which you are currently being treated including access to your medical information and records and provision of information following you discharge ***This is to allow those involved in your care to have access to your records and to be provided with relevant information about your medical condition. If you tick no, we may not be able to provide you with the service your require***	☐
5. To your local (or, where applicable, your referring) GP in a discharge summary	☐
6. To advise hospital affiliated associations of your presence in hospital, eg, RSL, Veterans Affairs Association, War Widows Association etc, if applicable	☐
7. To your family/carer to communicate your condition or discharge arrangements (where necessary)	☐
8. To or from medical practitioners, hospitals, health service providers, or external research organisations which we collaborate or partner with to assist in quality and research projects	☐

Declarations

- I have read and understood the information relating to the Collection and Use of my Personal Information.
- I understand that if I have **NOT** indicated 'NO' on this form that I consent to the use and disclosure of my personal information as set out above.
- I am authorised to sign this Form as, or on behalf of the patient named at the top of this page.

_____
Signature of patient / Date
(Unless patient is a minor or incompetent to sign)

_____
Signature of Parent / Guardian / Date
(If patient is a minor or incompetent to sign)

_____
Name of Patient

_____
Relationship to Patient

Consent for Personal Information

MR004