Transfer of Medical Records

Previous GP Name	
Practice Name	
Practice Address	
Phone No / Fax No	

I, _____ will now obtain my medical care from Dr Kirby White / Dr Erica Penno / Dr Nicole Lowe / Dr Ashwini Supperamohan, at The GP Clinic Bendigo, 81 Lucan Street, Bendigo. I provide my consent for my entire medical file and those files of any children under 16 years under my care to be provided to the above GP at The GP Clinic Bendigo.

Patient Authority

I request that you forward my medical file, including results, correspondence and plans and any letters, results or correspondence that you may receive in the future that relates to my medical care to the doctor and medical practice listed above, who will now be responsible for my ongoing care.

I provide my authority to The GP Clinic Bendigo to contact any specialists or allied health providers involved in my care and provide them with updated referrals and notify them to direct all future correspondence regarding my medical care to The GP Clinic Bendigo.

Patient Name				
Date of Birth				
Address				
Child 1	Name		DOB	
Child 2	Name		DOB	
Child 3	Name		DOB	
Signature				
Date				

THE gp CLINIC BENDIGO

Registration Form

As you are providing us with health information, please also read and sign a consent for to allow us to collect and use your health information.

Personal Details				
Titles	Gender	Date of Birth		
First Name	Surname			
Marital status ☐ Single ☐ Married ☐ Engaged ☐ Divorced ☐ De Facto ☐ Widowed				
Address				
Phone	Work	Mobile		
Email Address				
Medicare Number	Exp	PRN		
Pension No	Exp	DVA No		
Private Health Insurance ☐ Yes ☐ No				
Cultural Background/Ethnicity	Aboriginal / Torres Straight Islander ☐ Yes ☐ No ☐ Other			
Next of Kin Name and Contact Details				
Relationship to you				
Current Occupation	Or School			
Previous GP	Address			
Emergency Contact	Name	Relationship to you		
Telephone number	Mobile	Work		
Do you have any allergies to medicines or anything else? ☐ Yes ☐ No				
If yes, please list				
Cigarettes Non Smoker Ex Smoker Current Smoker	Alcohol ☐ Yes ☐ No			
Can we update a shared health summary to your My Health Record quarterly ☐ Yes ☐ No				
Can we contact you via text about appointments, reminders and preventative health ☐ Yes ☐ No				
Consent to referrals being sent electronically ☐ Yes ☐ No				

Health Information Collection and Use Consent Form

As a patient of our medical practice 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 health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to 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. Usually information that does not identify you is used but should information that will 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 eg notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.
- For the periodic update of a shared health summary in your My Health Record (unless you have already opted out of).
- Our clinic sends information to the Australian Immunisation Register.

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 to provide the best outcome for you.

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 other purpose other than set out above, my further consent will be obtained.	
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	
OR	
I am unsure and would like to discuss this further with someone from the medical practice before I sign.	

Patients Name		Patients Signature	
Patients Name		Patients DOB	
Name of guardian		Guardian Signed	
Date			