PRIVACY POLICY

The purpose of this document is to outline how Dr Dianne Poad complies with confidentiality and privacy obligations. Dr Poad's principal concern is and always will be the health of patients who visit the practice. A high level of trust and confidentiality is required to ensure the confidence of the patients served.
Patients will be assured that:

- their privacy will be protected when visiting Dr Poad;
- the information collected and retained in our records is correct and up-to-date; and
- that they can access their information for review.

Health information

Dr Poad recognises that the information collected from patients is often of a highly sensitive nature and, as medical practitioners, we have adopted the highest privacy compliance standards relevant to ensure personal information is protected.

For administrative and billing purposes, and to enable the patients to be attended to by other medical practitioners, patient information is shared between the medical practitioners and other health providers. Dr Poad and the medical practitioners may collect personal information regarding patients (including health information) for the purpose of providing medical services and treatment.

Personal information collected will generally include:

- the patient's name, address, telephone number and Medicare number;
- current drugs or treatments used by the patient;
- previous and current medical history, including, where clinically relevant, a family medical history; and
- the name of any health service provider or medical specialist to whom the patient is referred, copies of any letters of referrals and copies of any reports back.

Use or disclosure of personal information

Personal information collected by Dr Poad may be used or disclosed:

- for the purpose advised to the patient at the time of collection of the information;
- as required for delivery of the health service to the patient;
- as required for the ordinary operation of our services (i.e. to refer the patient to a medical specialist or other health service provider);
- as required under compulsion of law; or
- where there is a serious and imminent threat to an individual's life, health, or safety; or a serious threat to public health or public safety.

Dr Poad may use or disclose personal information for quality assurance, training, billing, liaising with government offices regarding Medicare entitlements and payments and as may be required by the medical practitioner's insurers.

Accuracy of your information

Dr Poad is committed to ensuring your information is accurate and has processes in place to ensure that the accuracy of this information is maintained. If you believe that the personal information held by Dr Poad holds about you is inaccurate, please inform Dr Poad or the attending medical practitioner when next attending the practice.

Accessing your information

On request, you may have access to your medical record held by Dr Poad or the attending medical practitioner, except in circumstances where access may be denied under the 'Privacy Act' or other laws. If you wish to access your personal information or make a complaint about a breach by us of your privacy, you can contact our reception on (07)3839-1033.

Contact information

If you have any queries regarding this Privacy Policy please contact: Dr Dianne Poad by Ph. (07)3839-1033 or email enquiries@dipoad.com.au
By signing the statement below, I confirm that I have read and understood Dr Poads' privacy policy and permit the use and disclosure of my personal information as set out therein.

____ _______________________

Name Signature Date

Your Details

Title: ❑Dr. ❑Mr. ❑Mrs. ❑Ms. ❑Other: ____________

First Name: ____

Surname: ____

Known As: ____

Occupation: ____

Address: ____

____

Suburb: ________________________

State: ________________________

Post Code: ____________

Date of Birth: ________________________ *i.e. dd/mm/yyyy*

Home Ph: ________________________ *Include prefix e.g.(07)3839-1033*

Mobile Ph: ________________________

Work Ph: ________________________

Medicare No.: ____

Ref. No: ________________________ *The number beside your name on the card*

Expiry Date: ________________________ *i.e. dd/mm/yyyy*

Private Health Fund: ____

Membership No: ____

Ref. No: ________________________ *The number beside your name on the card*

Partner Details

Title: ❑Dr. ❑Mr. ❑Mrs. ❑Ms. ❑Other: ____________

Name: ____

Occupation: ____

Date of Birth: ________________________ *i.e. dd/mm/yyyy*

Best Contact Ph: ________________________

Emergency Contact

Name: ____

Best Contact Ph: ________________________