DENTAL CARE ON BAY

Your Health Information – Privacy Consent Form

Our practice respects your right to privacy and it has systems and processes in place to ensure it complies with the Australian Privacy Principles (APPs). The practice privacy policy is available on request.

Our practice, **Dental Care on Bay ABN 58 627 936 472,** collects information about you for the purpose of providing health services to you. In addition, personal information such as your name, address and health insurance details are used for the purpose of addressing accounts to you, as well as processing payments and writing to you about our services and any issues affecting your health care. We may collect information about you from third parties providing the collection of that information is necessary to provide you with health care.

We may disclose your health information to other health care professionals, or require it from them if, in our judgement, it is necessary in the context of your care.

If you choose not to provide us with information relevant to your care, we may not be able to provide a service to you, or the service we are asked to provide may not be appropriate for your needs. Importantly, if you do not provide information that may be relevant to your care or that is otherwise requested by us, you could suffer some harm or other adverse outcome.

Your medical history, treatment records, x-rays and any other material relevant to your care will be stored by the practice. The practice privacy policy sets out how you can access your records or seek correction of your records.

The practice privacy policy sets out how you may complain about a breach of privacy and how the practice will deal with such a complaint.

The practice Privacy Officer can be contacted at the practice during business hours if you have any concerns or questions about a privacy matter.

Please sign this form as confirmation that you have read and understood the above information and consent to the collection and use of your health information.

Signed: _____

Date: _____

Patient/ Parent / Guardian Name:_____

Dependents:_____

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