



# SHARED CARE COMMUNITY CLINIC

## Patient Consent Form

The Shared Care Community Clinic requires your consent to collect personal information about you. Please read this consent form carefully, tick the applicable boxes and sign where indicated below.

This Shared Care Community Clinic collects such information for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history to allow us to properly assess, diagnose, treat and advise on all your health care needs. Please place a tick in the following boxes if you give consent for this information to be used by the Practice in the following ways:

I give my permission for my personal health information to be used for administrative purposes to assist in the running of the Shared Care Community Clinic, including disclosure to others involved in my healthcare, such as treating doctors and specialists within and outside this Medical Practice. This may occur through referral to other Doctors, or for medical tests and in the reports or results returned to my doctor following referrals.

I give my consent for disclosure for research and quality assurance activities to improve individual, community health care and Practice management. This may occur when the Practice incorporates patient health records into de-identifiable patient information to transfer to a third party, normally used for quality improvement projects. De-identifiable patient information cannot be traced back to the individual.

I give my consent to the presence of a third party to be present during my consultation. This may include a Specialist, Diabetes Educator Practice Nurse or medical student.

I understand by ticking the relevant boxes above that the Practice is authorized on my behalf to use my relevant personal health information and I am free to withdraw my consent at any one time by verbal or written notification.

***Complete section below if non-English speaking;***

I (name) \_\_\_\_\_ translated the above information to (name of patient) \_\_\_\_\_ and they have signed below. (Name of patient) \_\_\_\_\_ understands the Practice is authorized on their behalf to use their relevant personal information and they are free to withdraw their consent at any one time by verbal or written notification.

**Print name of Patient:** .....

**Signature of Patient:** ..... **Date:** .....