EXPERT INSIGHTS FOR PERSONALIZED HEALTHCARE

St. Andrews Health Specialists

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Patient Consent Form

Patient		Next of Kin	
First Name:		First Name:	
Family Name:		Family Name:	
Date of Birth:		Relationship to Patient:	
Aged Care Facility:		Mobile Number:	
		Email:	

Handling of Your Personal Information

We value and protect your Personal Information, including sensitive Health Information, as defined under the *Health Records Act 2001 (Vic)* and the *Privacy Act 1988 (Cth)*. This summary outlines how we collect, use, store, and share your data.

Collection of Information

We gather your Personal Information from documents and detail you provide, such as medical records, treatment plans, billing, and insurance information. This may include:

- Contact details
- Health Information (e.g., medical conditions, treatment recommendations, test results)

Your data is stored securely, either electronically or in physical form, and is only accessible to authorised staff.

Use of Information

Your Personal Information may be used for:

- Delivering medical care and treatment
- Maintaining accurate medical records as required by law and clinic policies
- Processing billing, including communication with private health insurers
- Meeting legal obligations under acts such as the *Medicare Australia Act 1973 (Cth)* and the *Health Insurance Act 1973 (Cth)*
- Other related purposes

Disclosure of Information

We may share your Personal Information with:

- Medical professionals, hospitals, or healthcare providers involved in your treatment
- Medicare, private health funds, or relevant organisations (e.g., Department of Veterans' Affairs, Workcover)
- Your designated Next of Kin in life-threatening emergencies
- Third parties when legally required

Fee Schedule

All services are bulk billed through Medicare, with no out-of-pocket costs for patients.
Applicable Medicare Item Numbers: Patients over 65: 145, 147, 128; Patients under 65: 132, 133
For more details, visit MBS Online or contact reception at 1300 100 724.

Consent

By signing, I confirm that:
I have read and understood this summary.
I consent to the collection, use, storage, and disclosure of my Personal Information as described.
I authorise the release of my medical records from doctors, hospitals, and other healthcare providers for ongoing care.
I assign my Medicare bulk-billing benefits to the consulting doctor for the specified services.

Patient/Next of Kin Signature: _____	**Date: _____**
Print Name: _____	