Grace Family Practice & Skin Care
Privacy Act Declaration

All information about you, held in this practice, is kept in confidence, because we value your privacy.
With the introduction of the Privacy Act Amendment (2000) in December 2001 we remain committed to protecting your privacy and are now asking for your express consent for the use and disclosure of your personal health information in the course of your healthcare. This consent allows those involved in your healthcare access to the information necessary to continue the high standard of health service you have come to expect of us.

CONSENT FOR USE & DISCLOSURE OF PERSONAL HEALTH INFORMATION IN THE DELIVERY OF HEALTH SERVICES

I consent to the use of my personal health information by the Grace Family Practice and health providers involved in my medical treatment healthcare and for the purpose of using a "recall and reminder" system to provide preventive care, including National and State reminders systems.

I consent to the disclosure of my personal health information by Grace Family Practice & Skin Care to other providers directly or indirectly involved in my personal healthcare or medical treatment.

PRIVACY ACT DECLARATION

<table>
<tr><td>Full Name</td><td>DOB</td></tr>
<tr><td>Date</td><td>Signature</td></tr>
<tr><td colspan="2">Declaration on Behalf of another person unable to comprehend or complete a personal declaration signed for and behalf of :
Patient Name: DOB</td></tr>
<tr><td>Your relationship to patient
Eg. Parent, Guardian , Carer, Power of Attorney</td><td>Your Full Name
(Please print)</td></tr>
<tr><td>Date</td><td>Signature</td></tr>
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More information regarding the privacy act is available at www.privacy.gov.au

I, the undersigned hereby understand that:

1. Following pathology or histopathology tests I should contact the surgery to be given the results of tests within 7 working days or as directed.
2. Following receipt of a notice form: pap smears, mammograms, pathology and immunization, I will undertake to make and attend follow up appointments.
3. I will consider all treatment and medical advice given to me by the doctors of Grace Family Practice and will not hold the Doctor responsible if I choose not to follow the advice given to me.
4. I will attend all appointments/ treatment arranged for me eg. X- Ray, pathology.
5. I will advise the relevant service provider if I cannot attend an appointment and make arrangements for an alternative appointment.
6. All of the fees are to be paid on the day of consultation unless I make special arrangements with my treating doctor.
7. I understand that if I do not attend an appointment, or give sufficient notice for cancellation of an appointment 3 times, I will be charged a fee of $50.

Signed: ....

Dated: ....

Received by Grace Family Practice Staff: ....