WAGGA ENDOSCOPY CENTRE

50 Best Street
WAGGA WAGGA 2650

Phone (02) 6921 2711
Fax (02) 6921 2201..

CONSENT TO USE INFORMATION FORM

Patient Name: ………………………………………….

At Wagga Endoscopy Centre the privacy of our patients is given high priority. During your admission in the facility we will need to collect your personal information to enable us to take care of you. We would like your consent to use your personal information for the reasons documented below.

Please read the information in this consent form carefully. If you **do not** understand anything contained in either document or have any questions **please do not sign this form** until you have had the matter clarified by our staff.

I hereby consent to the use of my personal information for the purpose indicated below:

* To inform my next of kin or person to contact for transport or in an emergency of the outcome of treatment or to obtain consent to necessary treatment when I am not able to provide such consent.

* For exchange of information with my General Practitioner, Specialist or Health Care Professional.

* For research and development projects undertaken by Wagga Endoscopy Centre in its own right, or in conjunction with medical practitioners who work in the facility. This information is not released to a third party.

* To allow access to specialists who are engaged to support the facility such as quality assurance, accreditation, certification and information technology specialists. These groups must also abide by the Privacy Act.

* To enable us to provide information to authorities such as Medicare, Veterans Affairs, Private Health Funds, Commonwealth and State Departments.

* To allow for my specialist to contact my health care professional (eg. GP) via email.

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Name (Print) **Signature** **Date**

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Revision 2
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