



Toorak Village

DENTAL CARE

SOLUTIONS THAT FIT

Your Health Information – Privacy Consent Form

In accordance with the *Victorian Health Records Act 2001* and *Federal Privacy Act 1998*

Our practice respects your right to privacy. We realise that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice and to whom this information might be disclosed

The policy of our practice is to follow these procedures:

1. The information collected on this form will be used for the purpose of providing treatment to you. Personal information such as your name, Address and health insurance details will be used for the purpose of addressing accounts to you, as well as processing payments and writing to you about any issues affecting your treatment.
2. We may disclose your health information to other health care professionals, or require it from them if, in our judgement, that is necessary in the context of your treatment. In that event the disclosure of your personal details will be minimised wherever possible.
3. We may also use parts of your health information for research purposes, in study groups or at seminars as this may provide benefit to other patients. Should that happen your personal identity would not be disclosed without your consent to do so.
4. Your medical history, treatment records, x-rays and any material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time, or seek an explanation from the dentist.
5. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

You can otherwise rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your prior written consent. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

Otherwise please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of your health information in this way.

Signed: _____ Date: _____

Patient/Parent/Guardian Name: _____