Dr Mark Doudle BMBS, FRACS
Specialist Colorectal Surgeon

PATIENT CONSENT

This medical practice requires your consent to collect personal information about you. Please read this information carefully and sign where indicated. All information collected and recorded will be held in accordance with the Privacy Act 1988 and Australian Privacy Principles (APPs).

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with personal details and a full medical history to properly assess, diagnose, treat and be proactive in your health care. We will also use the information provided in the following ways:

- Administration of this medical practice
- Billing, including compliance with Medicare / Health Insurance Commission and Health Fund requirements
- Disclose to others involved in your health care, including treating doctors and specialists outside this practice. This may occur through referral to other doctors or for medical tests with the reports / results returned to us following such referrals.
- Transfer of collected information for accreditation and quality assurance programs, clinical audits, medical defence, etc.
- Notification to Queensland Health of certain diseases (as required by law)
- Clinical photographs and video may be taken for use within the medical record. Where appropriate and with respect for your privacy, such anonymous images may be used for teaching and education.

I, ……..……..……. (please print clearly)
have read the information above and understand why collecting information about me is necessary.

I understand and acknowledge:

- I am not obliged to provide any information requested of me. I also understand that failure to do so may severely restrict the quality of health care and treatment given to me.
- I have the right to access the information collected about me, except in some circumstances where access may be legitimately withheld. I understand I will be given an explanation in these circumstances.
- If my information is to be used for any other purpose other than set out above, further consent will be obtained.
- I consent to the handling of my information by this practice for the purpose set out above, subject to any limitations on access or disclosure that I notify this practice of.

INFORMED FINANCIAL CONSENT - I understand that Dr Doudle charges are above the Medicare Australia and health fund schedule fees and out-of-pocket expenses may be charged to me in the course of professional services. I agree to be fully responsible for all costs and will pay all amounts due within 14 days of invoice or time frame set by Dr Doudle. Accounts forwarded to our debt collectors will incur a 25% administration fee added to the outstanding balance.

RADIOLOGY CONSENT - I understand that all radiology films held in this office will be destroyed after 4 months. (No radiology films will be posted)

CSSANZ Cancer Audit - I consent to my anonymous details being collected and used in the CSSANZ Cancer Audit. Please speak to Dr Doudle for more information.

I acknowledge that I have read this form before signing it and that Dr Doudle or a member of his staff has at my request clarified any aspect that I did not at first understand.

……. ……. / ……. / …….
Patient / Guardian's signature Date