Laser + Holistic Dental

Your Health Information - Privacy Consent Form

In accordance with the Victorian Health Records Act 2001 and Federal Privacy Act 1988 Our practice respects your right to privacy. We realize 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 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 our services and 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 judgment, that is it necessary in the context of your treatment. In that event, disclosure of your personal details will be minimized wherever possible.
3. We may also use parts of your health information for research purposes, in study groups, seminars, advertising and marketing. Should this happen then be assured that your personal identity will not be disclosed without your consent to do so.
4. Your medical history, treatment records, x-rays, photographs and any other 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. Statu- tory fees will apply in relation to the types of access you seek. If you request an explana- tion of our records or a written summary, our usual fees apply to these services.
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 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.

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: dd / mm / yyyy

Patient / Parent / Guardian Name: _____ Dependents: _____

Laser + Holistic Dental

A partner of 2nrich Wellness Centre

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