

WE RESPECT YOUR PRIVACY

In accordance with the Victorian Health Records Act 2001 and Privacy Act

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 much 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 professionals, or require it from them if, in our judgment, it is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimized whenever possible.
3. We may also use parts of your health information for research purposes, in study groups or seminars as this may provide benefit to other patients. Should this happen, your personal identity will not be disclosed without your consent to do so.
4. Your medical history, treatment records, x-rays and 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. Statutory fees will apply in relation to the type of access you seek. If you request an explanation of our records 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 the up most 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 your concerns with our practice.

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

Printed Name: _____

Signature: _____ Date: _____