



# Hunter Adult & Children's ENT

Konara, Suite 1 Level 3,  
15 Lambton Road  
BROADMEADOW NSW 2292  
Ph: (02) 4965 5411  
Fax: (02) 4965 5684  
Email: info@hunterent.com.au

## HEALTH INFORMATION COLLECTION AND USE - CONSENT FORM

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assist, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums, registrars attached to the practice for the purpose of patient care and teaching.
- Clinical Images – at times your Doctor may feel it beneficial and/or necessary to assist in your medical care to obtain a photograph of a lesion or the area involved in the treatment of your medical condition. These images form part of your medical record and will be stored in your electronic medical record.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to “opt out”: or any involvement. Any use of clinical images used for the purpose of training, education, research and/or publication will be depersonalized.
- To comply with any legislative or regulatory requirements eg; notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

- I have read the information above and understand the reasons why my information must be collected.
- I authorise for any medical information in regard to myself to be released to the specialists and locums at Hunter ENT.
- I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.
- I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.
- I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

**I do/do not consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.**

Patients Name: .....

Guardians Name (if applicable): .....

Patient or Guardian Signature ..... Date: .....



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**AUTHORITY TO OBTAIN MEDICAL RECORDS**

It is sometimes necessary to request medical information from hospitals/other doctors who have been involved in your care to assist in compiling a relevant medical history to effectively manage the patients treatment by Dr Eisenberg, A/Prof Kelvin Kong, Dr Toby Corlette, Dr Daron Cope, Dr Johnson Huang or one of our visiting Specialist ENT locums.

If the patient consents to the collection of medical information from another entity please sign the authority below:

I..... give authorisation for medical information in regard to the patient to be released to Dr Eisenberg, A/Prof Kelvin Kong, Dr Toby Corlette, Dr Daron Cope, Dr Johnson Huang or a visiting ENT Specialist of Hunter ENT.

Patient's Name: ..... D.O.B. ....

Guardians Name (if applicable): .....

Patient or Guardian Signature:..... Date:.....

I..... give permission for Dr Eisenberg, A/Prof Kelvin Kong, Dr Toby Corlette, Dr Daron Cope, Dr Johnson Huang or a visiting ENT Specialist of Hunter ENT to provide verbal/written health information to these nominated persons:

**NAME:**

**RELATIONSHIP TO YOU:**

.....  
.....  
.....

.....  
.....  
.....

Patient's Name: ..... D.O.B. ....

Guardians Name (if applicable): .....

Patient or Guardian Signature:..... Date:.....

PATIENT BACKGROUND INFORMATION



Title:.....First Name:.....Middle:.....Surname:.....

Address:.....Suburb:.....Postcode:.....

Home phone:.....Work:.....Mobile:.....

Email:.....D.O.B:.....

Do you agree to receive SMS for appointment confirmations : Yes / No

For children: Parent's Name: Mother: .....Ph:.....

Father: .....Ph:.....

Contact person in case of an emergency:-..... Relationship to you:- .....

Ph: Home:- ..... Work:- ..... Mobile:- .....

Are you of Aboriginal or Torres Strait Islander origin?  Aboriginal  TSI  Neither

Who is responsible for the account:-  Myself  Workers Comp Insurer or other Third Party (please also complete Insurers Details below)

Medicare No:- \_\_\_\_\_ Your ref no. \_\_\_\_\_  Expiry date:- \_\_\_\_ / \_\_\_\_

Medicare Ref No of Parent if patient is Child : Ref No \_\_\_\_ D.O.B. Parent .....

DVA No:- ..... Gold Card?  White Card?  if white, please specify condition:- .....

Pension No:-.....

Health Fund Name:- ..... Membership No.:- .....

Third Party Insurer Details (for Worker's Comp or Insurance Claims only):-

Insurer: ..... Claim Number (if applicable):- .....

Insurer's Address:- .....

Claim Officer:- ..... Contact no.:- .....

Employer:- .....Date of accident (if applicable):- .....

General Practitioner:- ..... Suburb:.....

Current Medications (especially blood thinning, eg. Aspirin, Warfarin, Clopidogrel):- .....

Are you allergic to penicillin or any drugs or medicines? .....

Are you a smoker? Yes / No .How many per day?..... How long have you been smoking for?.....(years)

Occupation - ..... Females: Are you pregnant? .....

Have you had any illnesses requiring admission into hospital in the past 2 years? .....

Have any of the following occurred in your medical history (please circle)?

- heart trouble / murmur arthritis blood pressure lung disease anaemia kidney disease
blood transfusions stroke asthma epilepsy hepatitis diabetes
infective endocarditis sinusitis joint replacement heart surgery Warfarin rheumatic fever

Are you in an at-risk group for Hepatitis B, Hepatitis C or Acquired Immune Deficiency Syndrome? .....

Has your doctor warned you that precautions need to be taken before operations? .....

Is there anything else about your health we should know? .....



**KONARA**  
**BROADMEADOW**  
Appointments  
**PH: 49655411**

Email: [bookings@hunterent.com.au](mailto:bookings@hunterent.com.au)

**Dr Robert Eisenberg A/Prof Kelvin Kong Dr Toby Corlette**  
**Dr Daron Cope Dr Johnson Huang**



**Maitland Clinics—By appointments through our Broadmeadow office only**

**ALL BOOKINGS: HUNTER ENT**  
**KONARA**

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Clinics at Maitland Private Hospital  
please phone Broadmeadow rooms for  
information

