Northern Pain Centre
Level 4, Suite 6
North Shore Private Hospital
Westbourne St, St Leonards,
NSW, 2065
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E admin@northernpaincentre.com.au

CONSENT TO COLLECT PATIENT INFORMATION

Northern Pain Centre and the Empower Pain Management Program collect information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors, your insurer, your rehabilitation provider, your employer and specialists outside this medical practice as advised by you.
4. To compile a report of your progress throughout the Empower Pain Management Program to your General Practitioner and Worker's Compensation Insurer.
5. Research purposes*

**Your de-identified information may be used for research purpose.*

As part of the collection of your data for research purpose we agree to:

1. Store the data in a secure manner and only for an agreed time period related to the purpose of the research.
2. Not provide the data to any person who is not named in this consent form.
3. Not link the data to any other dataset.
4. Not attempt to identify individuals or providers by any process, including by linkage with another dataset.

If you do not wish to have your information used for research purpose please tick the box ☐

The people I consent to have information disclosed to outside of my General Practitioner and Worker's Compensation Insurer are:

Full Name/Contact Details: ____

Full Name/Contact Details: ____

Full Name/Contact Details: ____

Full Name/Contact Details: ____

Consent

- I understand the reasons why my information must be collected.
- I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.
- I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.
- I understand that if my information is to be used for any purpose other than the above, my consent will be sought.
- I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

____

Signature Today's Date (dd/mm/yyyy)

____

Please Print Full Name Date of Birth (dd/mm/yyyy)