sydney prosthodontics
specialist restorative and preventive dentistry

Privacy Consent Form

To comply with the Privacy Act 2001, all patients need to provide written consent for the following important aspects of their medical/dental care.

This Specialist Practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use this information you provide in the following ways:

1. ***Administrative purposes in the running our specialist practice and the collation of comprehensive clinical records. This includes the use of AI notation software that necessitates the recording of all consultations. These technologies assist in improving the accuracy of clinical records, treatments discussions and treatment planning.***

2. ***Billing purposes, including compliance with Health Insurance Commission requirements***

3. ***Disclosure to others involved in your dental health care. This may include treating dentists, specialists, allied health care personnel outside this specialist practice and any third party that is involved with your case. This may occur throughout referral to other dental care providers, investigative tests, reports or results returned to us following referral. I agree that the consultation takes place with a registered dental nurse in attendance.***

4. ***To conduct practice audit and clinical research, in which case all data anonymised. We conduct audit and research which are an important way of maintaining high standards of prosthodontic practice.***

Tick the following additional consents to acknowledge acceptance of terms and complete by signing below:

☐ I authorise the taking of x-rays, study models, photographs and any other diagnostic aids deemed necessary to assist in thorough diagnosis of my dental needs.

☐ I agree to the recording of my clinical consultation to assist in collation of comprehensive clinical records. (these recordings are not shared with any third party and transcripts are deleted once clinical records are finalised)

☐ I agree and consent to allow the photographs taken before, during, and after completion of my dental treatments to be used for dental records, research, education, public relations, and patient counselling. I agree and consent that the related photographs may be published and re-published, either separately or in connection with each other in dental photo albums, professional journals, or dental books.

☐ I authorise the doctor to perform all recommended treatment, mutually agreed upon by me (the patient), and to employ such assistance as required to provide proper care.

☐ I have read the information above and understands the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information. The practice will not provide information regarding my dental condition , appointments etc to anyone, including family members, unless I have agreed to this in writing.

☐ I understand that I am not obliged to provide any information requested but that failure to do so might compromise the quality of the dental care and treatment provided to me.

☐ I am aware of my right to access the information collected about me.

Signature of Patient _____ Date _____

Patient Name (*please print*): _____