Acknowledgment and Disclaimer

Family Name:____________________ MR/UR No: ______________
Given names: ____
Address: ____
Postcode: _______________ DOB: __________________________
Doctor: ____

(or please affix Patient Identification Label here)

PROPERTY AND VALUABLES

I acknowledge that:

1. The hospital does not take any responsibility for the loss of any items I keep with me during my hospitalisation;
2. The hospital has recommended that I do not keep any jewellery, credit cards, cash (in excess of the sum of $50.00) or other valuables with me whilst I am a patient in this hospital;
3. It is preferable if I arrange for any valuables in my possession to be taken home upon my admission to the hospital, or if that is not possible, that I hand over my valuables to the hospital to keep in safe custody;
4. The hospital has the right to sell or otherwise dispose of any property, including valuables, which I leave in the possession of the hospital for more than 3 months after the date of my discharge; and
5. I will notify the staff of any valuables brought into the hospital or removed from the hospital after admission.

SIGNATURE: ________________________________ **PRINT NAME:** ______________________________
(Patient / Legally Responsible person)

________________________________ ______________________________
Relationship to Patient Date

RIGHTS AND RESPONSIBILITIES

I have read the information relating to my Rights and Responsibilities.

I understand these Rights and Responsibilities and agree to abide by my responsibilities in relation to my admission to the Hospital.

I am aware I can discuss any queries I have with the staff.

SIGNATURE: ________________________________ **PRINT NAME:** ______________________________
(Patient / Legally Responsible person)

________________________________ ______________________________
Relationship to Patient Date

CONSENT FOR THE USE OF PERSONAL INFORMATION

I have read the information relating to Personal Information and Privacy for Patients and understand my right to privacy and how my personal information will be used at the Hospital.

I consent to the collection, use and disclosure of my personal information for the purposes set out in it and for any directly related purpose.

I am authorised to sign this Form as, or on behalf of, the patient named at the top of this page.

I understand that if I have any concerns about privacy issues, I may raise them when I come to hospital for admission.

IF YOU DO NOT WISH YOUR PERSONAL INFORMATION TO BE USED FOR A SPECIFIC PURPOSE, PLEASE COMPLETE THE FORM ON THE NEXT PAGE. DO NOT SIGN THIS SECTION.

SIGNATURE: ________________________________ **PRINT NAME:** ______________________________
(Patient / Legally Responsible person)

________________________________ ______________________________
Relationship to Patient Date

Acknowledgment and Disclaimer

Family Name:___________________ MR/UR No: _____________
Given names: ____
Address: ____
Postcode: ______________ DOB: ________________________
Doctor: ____

(or please affix Patient Identification Label here)

CONSENT FOR THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

If you DO NOT want us to use or disclose your personal information in any of these ways please tick the box in the column to show you do not give consent.

Note: If there is no response by you against an item it will be taken to mean that you agree with that use.

USES OF PERSONAL INFORMATION...	NO
1. To train and educate professional staff	☐
2. For health and medical research projects we undertake solely or in conjunction with related research organisations and external research organisations with which we collaborate or partner. *You will not be identified in any research publication.*	☐
3. To assist in the development of service delivery and planning facilities.	☐
4. To tell you about fundraising activities	☐
5. To tell you about marketing promotions	☐
DISCLOSURES OF PERSONAL INFORMATION...	**NO**
6. To or from other medical practitioners, hospitals or health service providers to assist in any current or future treatments that relate to the condition for which you are currently being treated including access to your medical information and records and provision of information following your discharge. *This is to allow those involved in your care to have access to your records and to be provided with relevant information about your medical condition..*	☐
7. To your local (or, where applicable, your referring) GP in a discharge summary.	☐
8. To advise hospital affiliated associations of your presence in hospital, eg. RSL, Veterans Affairs Associations, War Widows Association, etc. if applicable.	☐
9. To your family/carer to communicate your condition or discharge arrangements (where necessary)	☐
10. To or from other medical practitioners, hospitals, health service providers, Wesley Research Institute Limited, St Andrew's Medical Institute Foundation Limited, or external research organisations which we collaborate or partner with to assist in quality and research projects.	☐

Declarations:

- I have read and understood the information relating to the Collection and Use of my Personal Information. I do not consent to the collection, use and disclosure of my personal information for the purposes set out in this document.
- I am authorised to sign this Form as, or on behalf of, the patient named at the top of this page.

______________________________	______________________________
SIGNATURE OF PATIENT / DATE (Unless patient is a minor or incompetent to sign)	SIGNATURE OF PARENT/GUARDIAN / DATE (If patient is a minor or incompetent to sign)
______________________________	______________________________
NAME OF PARENT/GUARDIAN	RELATIONSHIP TO PATIENT