REMEDY HEALTHCARE CONSENT FORM

PHONE 1300 734 224 | FAX 1300 734 221

By signing this form, you are consenting to participate in a program or services provided by Remedy Healthcare and acknowledge that you have read and understood the terms listed below.

1. CLIENT DETAILS

Client Name:	Client Address:
Client phone:	
Client DOB:	

- Agree that information about my medical condition and care needs can be shared with:
  - my referring private hospital,
  - my local doctor and/or treating specialist,
  - Remedy Healthcare care coordinators and other Remedy Healthcare staff,
  - other health care agencies who may be continuing my treatment.
- Understand that Remedy Healthcare will keep my personal information (which includes health information) secure and confidential and will only use and disclose such information in connection with my case as permitted under the Privacy Act 1988 (Cth) and Remedy Healthcare's privacy policy which is available online at remedyhealthcare.com.au or by calling 1300 734 224.
- Agree that my case information (de-identified) may be used by Remedy Healthcare for quality monitoring, reporting and evaluation purposes.
- Understand that Remedy Healthcare provides care coordination and arrangement of clinical services (nursing, allied health) and non-clinical services (personal care, home care, meals) only and does not provide emergency medical care.
- Understand that care coordination services provided by Remedy Healthcare are available from Monday – Friday during business hours.
- Understand that in the event of a medical emergency, I will dial 000 or contact a family member or my carer, and/or my local doctor.
- Understand that my calls may be recorded.

2. DELEGATED AUTHORITY

Complete this section to authorise a specific person(s) (e.g. your next of kin) to speak on your behalf for the duration of your program or services with Remedy Healthcare.

By providing your signature, you authorise the nominated person(s) to provide and be provided with information regarding your condition and matters concerning your medical records, collected for the purpose of the program, and general health, as required.

	Nominated Person 1	**Nominated Person 2**
Nominated Person (full name)		
Relationship to Client		
Nominated Person Address		
Nominated Person Phone		

3. SIGNATURE

Signature:	Date:
If the client is unable to give consent, a carer or guardian may sign below on his/her behalf.	
Carer/Guardian Signature:	Date:
Carer/Guardian Name:	Relationship: