north east family medicine

19 Norton Street Wangaratta Vic
Phone: 03 5723 5400
Web: northeastfamilymedicine.com.au
Email: admin@northeastfamilymedicine.com.au
ABN: 57 485 501 532

Personal health information collection statement

The Privacy Act 1988, and the Health Records Act 2001, determine how organisations such as North East Family Medicine, collect, store and who has access to information about you.
This information sheet aims to explain how we collect and administer your health information. Your doctor will be happy to discuss this with you.
Why do we collect personal and health information?
To ensure we provide high quality care and improve the quality of our services and administer those services to fulfil our obligations as required by law
How do we collect personal information?
North East Family Medicine collects information regarding each patient, from the patient, parent or guardian. This information is normally collected when the patient first attends our Practice.
Our Practice is fully computerised. Information is kept secure at all times and any paper files which have not yet been scanned to computer, are protected and kept secure in a staff only area. The computer data is backed up each night and the success of the backup is verified regularly to ensure retention of the data.
Clinical information such as medications, classifications, allergies, immunisations, family history and social history are obtained by the doctor. Clinical notes are recorded either during the consultation or on completion. Prescriptions, specialist and allied health referrals, pathology, x-ray and ultrasound requests are computer generated. Clinical information can only be accessed by Doctors, Nurses, Allied Health care workers and specially authorised administrative staff.
Your personal health record
Your doctor will aim to make sure that your medical records:-

- Are accurate, comprehensive, well organised and legible
- Are up to date
- Have enough information to allow another doctor to care for you
- Do not contain irrelevant or offensive comments about you
- Contain a summary of your care and can remind you, with your permission, to return for follow up, checkups and reviews.

What personal information do we collect and hold?
Reception staff collect personal information such as name, address, date of birth, ethnicity, contact telephone numbers, next of kin (NOK) and Medicare card number, reference number and expiry date. This information is recorded and forms the basis of your computer file. Each patient is allocated a unique individual patient file. Your details will be updated regularly to ensure your file is kept up to date. Patients can ask for their personal information to be corrected or updated at any time.
For patients who are eligible for Veteran Affairs, their card status and number is recorded. For patients who hold a Health Care Card, Pension Card or Seniors Health Care Card, the number and expiry date is recorded. For patients who have a claim with WorkCover or TAC, an accident date, claim number and employer may need to be recorded.

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We receive a combination of electronic and paper based results and correspondence. All paper based results and correspondence are scanned into the patient's file enabling us to have a fully computerised patient record.
For referred services, the doctors gain consent from the patient during the consultation. Only relevant patient information is released to these service providers.
Providing your information to other health care providers
All patients have a general right of access to their own health records. When requesting information, to assist our Practice, we will require specific details about what type of information is required. When access is sought, it may be useful to make an appointment with your Doctor to discuss your health information, to prevent the information being misunderstood or taken out of context. Some requests for information may need to be in writing.
Some information may be provided with a verbal request.
Administrative staff are not authorised to provide clinical health information to patients therefore these requests will be referred to the appropriate Doctor.