**ONLINE GENERAL PRACTITIONER SERVICE – CONSENT FORM [Form NJF01]**

**Purpose of this form**

This form is used to confirm that you consent to your treating health professionals and/or health providers at [INSERT LEGAL ENTITY NAME OF PARTY MANAGING THE ALLIED HEALTH PRACTITIONERS AT RELEVANT SITE ACN 123 456 789] (‘Allied Health Practitioner/s’) disclosing relevant information about your disability or medical conditions to Telstra Corporation Limited (ABN 33 051 775 556), Telstra Health Pty Ltd (ABN 38 163 077 236) and Telstra ReadyCare Pty Ltd (ABN 29 601 537 928) (‘HealthNow’) being the suppliers of Telstra Health Products. You acknowledge this information is required to be disclosed so that your Allied Health Practitioner can submit on your behalf Referral Request/s to HealthNow doctors so that they may assess and confirm your eligibility for the health care services sought by you from the Allied Health Practitioner/s as a patient eligible for such health care services as funded under a scheme administered by the Department of Veteran’s Affairs (‘the Services’).

By using any Telstra Health Product you agree to be bound by the Terms of Use. If you do not agree to these Terms of Use (or the corresponding privacy statement) then you must not use any Telstra Health Products.

The Terms of Use can be viewed at

<https://www.healthnow.io/content/healthnow/terms.html>

The Privacy Statement can be viewed at <https://www.healthnow.io/content/healthnow/privacy.htm>

In this form the terms ‘Telstra Health Services’, ‘TeleHealth’ and ‘HealthNow’ have the same meaning as that set out in the Terms of Use document referred to above.

**Acknowledgements**

You acknowledge the following criteria for provision of the Services as set out below:

You have a regular treating General Practitioner (‘GP’) overseeing your general health care and treatment plans.

You acknowledge that all other communications and requests relevant to your general health care which do not specifically relate to the Services and terms of use as set out in this document must be directed to your GP.

You acknowledge HealthNow doctors are responsible only for undertaking a standard assessment of your health care needs relevant to the provision of the Services with a view to assessing your eligibility, and that such assessment will be based on the information provided by you in your Referral Request.

You acknowledge HealthNow may require you to attend a TeleHealth appointment if more information is required in order to adequately assess your eligibility for the Services. In some instances, particularly if your Referral Request contains complex matters or has not been completed with sufficient detail to enable HealthNow doctors to adequately assess your health needs, you may be required to re-attend your GP to obtain a referral confirming your eligibility to the Services.

As a patient of the Allied Health Practitioner/s you agree to the Allied Health Practitioner/s providing the Services to you and submitting your Referral Request to HealthNow on your behalf.

You can complete this Consent to Disclose Personal Information on this form to provide your consent. You acknowledge that you have previously provided your consent to the terms contained in this form by verbal agreement over the phone to a representative of the Allied Health Practitioner/s and that you now complete this form as written evidence of your earlier verbal agreement.

You can withdraw you consent at any time by advising HealthNow or your Allied Health Practitioner/s. However if your health professionals and/or health providers do not disclose relevant information when requested, you may not obtain a current referral to obtain Services and may be required to pay for the Services which are no longer eligible for funding.

**Important Information**

If more information is needed to assess your eligibility for the Services, HealthNow or your Allied Health Practitioner/s may contact your GP to confirm or clarify information you provide about your disability or medical conditions. This may include contact with any health professionals (including your GP) and/or health providers who have examined, diagnosed or treated your disability or medical conditions which are relevant to your eligibility for the Services.

Your personal information is protected by law (including the *Privacy Act 1988*) and is collected by the Allied Health Practitioner/s and HealthNow for assessment and administration and provision of Services to you.

**Consent to disclose medical information**

I, (full name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_/\_\_/\_\_\_\_

of (address)

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Postcode: \_\_\_\_\_\_\_\_

give consent for my Allied Health Practitioner/s to disclose any relevant information about my disability or medical conditions to my GP or HealthNow to assess my medical condition relevant to my eligibility to obtain the Services.

Your Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_/\_\_/\_\_\_\_