Dr Susan Hinckfuss
B.D.Sc (Melb), D.C.D (Melb)
Specialist Paediatric Dentist
Coates Building, Suite 5, Level 11 20 Collins St, Melbourne 3000
Tel: (03) 96509321 Fax: (03) 96541203

YOUR HEALTH INFORMATION AND OUR PRIVACY POLICY
In accordance with the Victorian Health Records Act 2001 and Privacy Act

This practice respects your right to privacy. We realise it is important that you understand the purpose for which we collect details about your health. It is also important that you are informed as to how this information is used at the practice and to whom this information might be disclosed.
The policy of this practice is to follow these procedures:

1 The information collected will be used for the purpose of providing treatment to you. Personal information (such as your name, address and health insurance details) will be used for the purpose of addressing accounts to you and processing payments. It may also be used when writing to you about our services and any issues affecting your treatment.
2 We may disclose your health information to other health care professionals, or require it from them if, in our judgement, this is necessary in the context of your treatment. In that event, disclosure of your personal details will be kept to a minimum.
3 We may use parts of your health information for research purposes, in study groups or at seminars where this information may be of benefit to other patients. In that event, disclosure of your personal details will be minimised wherever possible.

4 Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time, or seek an explanation from the dentist. Statutory fees will apply in relation to the types of access you seek. Should you request an explanation of our records or a written summary, our usual fees will apply to these services.
5 If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.
You can otherwise rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your prior written consent. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

Please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of your health information in this way.

Signed .....Date .....

Patient/Parent/Guardian Name.....

Dependents .....