

CONSENT TO COLLECT PATIENT INFORMATION

Our Privacy Policy at March 2014 outlines Dr Amanda Chung's information handling practices, including the way we collect and use your information and how you can access your information.

If you have questions in relation to this consent form or our Privacy Policy please ask one of our staff who would be more than happy to assist.

Please provide you consent to our collection and use of your health information by signing and dating the form where indicated.

PLEASE CIRCLE

I do/do not consent to Dr Amanda Chung and her staff using my health information to manage my condition, treatment and/or diagnosis.

I do/do not consent to being contacted by Dr Amanda Chung or her staff with the possibility in participating in future research.

I do/do not consent to de-identified (anonymous) information/images/videos from my medical file being used for education or research purposes and/or for publication to further medical knowledge in this treatment area.

Patient's Name

Patient's Signature

Witness' Name

Witness' Signature

Date