

# MEDICAL CONSENT FORM

Patient Full Name: \_\_\_\_\_

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

Address: \_\_\_\_\_

## Medical Practitioner Information:

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Consent Details:

I hereby give my voluntary consent for medical examination, treatment, and/or surgery as deemed necessary by my medical practitioner or their delegate. I acknowledge that my medical practitioner has explained the nature and purpose of the procedure(s), potential risks, benefits, and alternatives to the proposed treatment to my satisfaction. I understand that no guarantees have been made regarding the outcome of the treatment.

## Privacy and Confidentiality:

I understand that all medical information collected during the course of my treatment will be handled in accordance with the Privacy Act 1988 (Cth) and the Australian Privacy Principles to protect my personal and health information. I consent to my information being shared with relevant healthcare providers involved in my treatment and care.

## Voluntary Participation and Right to Withdraw:

I confirm that I am participating voluntarily and may withdraw my consent at any time before or during treatment without compromising my access to future healthcare services.

## Acknowledgment of Understanding:

I confirm that I have had the opportunity to ask questions and that all my questions have been answered satisfactorily. I understand this consent form and agree to the terms stated within.

## Emergency Contact Information:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Signatures:

**Patient Signature**

**Medical Practitioner Signature**

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Date Signed: \_\_\_\_\_

This Medical Consent Form is intended to comply with applicable Australian laws. The patient's signature confirms informed consent has been given in accordance with

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