

Opt-out form – Adults, Parent/ Guardian or Person Responsible



Declaration by adults, a parent/guardian (on behalf of a child or minor) or person responsible (on behalf of a person who is unable or not competent to provide consent for themselves)

I am signing this form because I want to opt out of the MedicineInsight program. When I sign the form, I am accepting the following things:

- I have read the Information Sheet, or someone has read it to me in a language that I understand.
- I have had the opportunity to ask questions about MedicineInsight. The practice has explained the program to me, and my questions have been answered.
- I understand that the practice will stop releasing my information, or information associated with the person for whom this opt-out form is being signed, to MedicineInsight and recognise that it may not be possible to withdraw information collected up until the point of this opt-out.
- I understand the decision to opt out of MedicineInsight will not influence the health care I, or the person on behalf of whom this decision is being made, will receive now or in the future.

Please tick this box if you want to opt out of the MedicineInsight program:

- ▶ I want to opt out of the MedicineInsight program

Please tick this box if you are completing this form on behalf of someone else:

- ▶ I am completing this form on behalf of a child/minor or a person who is unable or not competent to provide consent for themselves.

▶ Name of person:	Age (in years):
.....	
▶ Name of parent/guardian or person responsible:	
<small>If you are signing on your own behalf, leave this blank.</small>	
.....	
▶ Address:	
.....	
▶ Signature:	Date:
.....	

Please return this completed form to your GP or the practice reception.

FOR OFFICE USE ONLY

I have removed the patient from the MedicineInsight data collection tool

I have taken action to make sure that MedicineInsight tool does not collect the information in the patient's medical record

Name of action officer:	Signature:	Date:
.....

The practice must keep this form for practice records in a secure place. Do not return this document to the Australian Commission on Safety and Quality in Health Care.