AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

MedicineInsight

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 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. Translated copies of the Information Sheet can also be found at: https://www.nps.org.au/medicine-insight/patient-and-provider-information
- 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	
Name of parent/guardian or person responsible. **If you are signing on your own behalf, leave this blank.*	
Address	
Age (in years)	

Signature: _____ **Date:** _____

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

***FOR OFFICE USE**

☐ 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. For additional information call MedicineInsight on 1300 721 726. RACGP NREEC, Ref. 23-171, Version 2, May 2023.