RWHIP4A

THE ROYAL WOMEN'S HOSPITAL

CONSENT - PARKVILLE CONNECT

Please complete this form and fax or email to: Heath Information Services Fax: 03 8345 2642
Email: HIS@thewomens.org.au Phone: 8345 2616

This form is only to be completed for health professionals who are registered or are to become registered users of Parkville Connect. By signing this form, you enable The Royal Women's Hospital to provide access to the EMR Parkville Connect Portal to the nominated health care provider listed on this form.

This will allow a nominated health professional to get access to the patient's record where the nominated health care provider is not their usual GP.

Parkville Connect

Parkville Connect is a secure website that connects GPs, specialists and other healthcare professionals with information in the Parkville electronic medical record (EMR), for The Royal Women's Hospital, The Royal Melbourne Hospital, The Royal Children's Hospital and Peter MacCallum Cancer Centre.

GPs, specialists and other healthcare professionals must be registered to access Parkville Connect.
Registered users will get secure, read-only access to information such as:

- Upcoming hospital visits
- Discharge summaries and after visit summaries
- Inpatient and outpatient progress notes
- Allergies, medical history and medications

For providers who are not currently signed up to Parkville Connect:
Go to parkvilleconnect.org.au or contact support@parkvilleconnect.org.au. We use The National Health Services Directory (NHSD) to verify practice and health professional details. Details can be updated in the NHSD by contacting: nhsd@healthdirect.com.au

Details of Patient:

First name:_____ Surname: _____

Date of Birth:_____ Gender:_____ Phone number: _____

Address:_____ RWH MRN:_____

Details of Provider:

First name:_____ Surname:_____

Practice name: _____

Address:_____ Postcode:_____

Phone number:_____ Fax:_____

Health Provider Relationship: ☐ Primary GP ☐ Other GP ☐ Specialist

☐ Other (please specify) _____

Patient Consent - Parkville Connect:

☐ *I, the above named patient authorise for the above named provider to be granted access to my health information for my ongoing care. I understand the records are shared across The Royal Women's Hospital, Peter MacCallum Centre, The Royal Melbourne's Hospital and The Royal Children's Hospital.*

Patient Signature:_____ Date: _____

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