METRO NORTH HOSPITAL AND HEALTH SERVICE
Oral Health Service

Proxy Access to Centrelink Information

Facility: ……………………………………………………………...................

(Affix identification label here)

Family Name:

Given Name:

Address:

Date of birth: / / Sex: ☐ M ☐F

PCC/HCC No: ______ ______ ________ ______

Dependant Yes ☐ No ☐

If yes name of person you are dependant of:

____

PCC/HCC number of person you are dependant of:

______ ______ ________ ______

Customer Consent Script

This form is used for customers, 16 years of age and over, to provide consent for Queensland Oral Health Service staff to access Centrelink concession card information. This is to assess your eligibility in relation to concessions or services provided by the Queensland Health Oral Health Service. The Queensland Oral Health Service is committed to maintaining strict confidentiality in all aspects of service delivery.

Customer Confirmation

I ……………………………………………………………..….. (name of customer) authorise:

- the Queensland Health Oral Health Service to use Centrelink Confirmation eServices to perform a Centrelink or Department of Veterans' Affairs (DVA) enquiry of my Centrelink or DVA Customer details and concession card status in order to enable the business to determine if I qualify for services.
- the Australian Government Department of Human Services (the Department) to provide the results of that enquiry to the Queensland Health Oral Health Service.

I understand that:

- the department will use information I have provided to the Queensland Health Oral Health Service to confirm my eligibility for services and will disclose to the Queensland Oral Health Service personal information including my name, address, payment and concession card type and status.
- this consent, once signed, remains valid while I am a customer of the Queensland Oral Health Service unless I withdraw it by contacting the Queensland Oral Health Service or the Department.
- I can obtain proof of my circumstances/details from the department and provide it to Queensland Oral Health Service so that my eligibility for services can be determined.
- if I withdraw my consent or do not alternatively provide proof of my circumstances/details, I may not be eligible for the services provided by the Queensland Health Oral Health Service.

Customer/Guardian signature:

Date:

Office Use Only

Date Verified: / / Checked by: ___________________________

Eligible ☐ Non Eligible ☐

DO NOT WRITE IN THIS BINDING MARGIN