Australian Government
Services Australia

medicare

Practice Incentives Program Indigenous Health Incentive patient withdrawal of consent (IP029)

When to use this form

Use this form to withdraw your consent to participate in the Practice Incentives Program (PIP) Indigenous Health Incentive. For patients under 15, this form must be completed by a parent or guardian.

For more information

Go to **servicesaustralia.gov.au/pip** or email **pip@servicesaustralia.gov.au**

There may be risks with sending personal information through unsecured networks or email channels.

If you need assistance completing this form, call **1800 222 032** Monday to Friday, 8.30 am to 5 pm, Australian Central Standard Time.

Call charges may apply.

Filling in this form

You can fill this form digitally in some browsers, or you can open it in Adobe Acrobat Reader. If you do not have Adobe Acrobat Reader, you can print this form and complete it.

If you have a printed form:

- Use black or blue pen.
- Print in BLOCK LETTERS.

Patient details

1 Medicare card number

Ref no.

2 Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

First given name

3 Your date of birth (DD MM YYYY)

4 Do you agree to the practice submitting this form on your behalf?

No ☐
Yes ☐

5 Do you consent to Services Australia contacting the practice to confirm information needed to process this form?

No ☐
Yes ☐

Practice details

6 Practice ID (if known)

7 Practice name

8 Full practice address

Building name

Unit Suite Shop Floor number

Street number

Street name

Suburb/Town

State Postcode

Privacy notice

9 Your personal information is protected by law (including the *Privacy Act 1988*) and is collected by Services Australia for the purposes of the Practice Incentives Program (PIP).

Your personal information will be disclosed to Australian Government Department of Health and Aged Care to enable that department to administer aspects of PIP, including for program compliance purposes, for statistical and research purposes and to inform policy development.

Your personal information may be used by Services Australia, or given to other parties where you have agreed to that, or where it is required or authorised by law (including for the purpose of research or conducting investigations).

You can get more information about the way in which Services Australia will manage your personal information, including our privacy policy, at **servicesaustralia.gov.au/privacy**

Patient's declaration

10 **I acknowledge that**:

- by completing this form I am withdrawing my consent to participate in the Practice Incentives Program Indigenous Health Incentive.

I declare that:

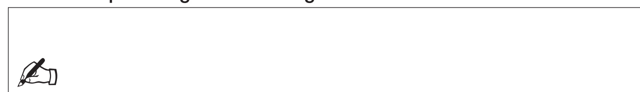
- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Patient ☐
Parent ☐ Guardian ☐

Patient or parent/guardian's full name



Patient or parent/guardian's signature

✍

Date (DD MM YYYY)

Returning this form

Return the completed form and supporting documents by fax to **1300 587 696**.