



### GP details for Shared Antenatal Care (SAC) register

To complete this form using Adobe Acrobat first 'Save' the document to your computer, then 'Open' in Adobe and select the 'Fill & Sign' button. Once completed re-save the form and return via email. If you do not have access to Adobe Acrobat then please complete the form by hand.

<b>GP Name:</b>	
<b>Practice Name:</b>	
<b>Practice Address:</b>	
<b>Mailing Address</b> If different from above	
<b>Practice Phone:</b>	
<b>Practice Fax:</b>	
<b>Mobile or Home Phone (optional):</b>	
<b>Email:</b> (For communication regarding updates and education events)	<input type="checkbox"/> For SNHN use only
<b>AHPRA Registration #: MED</b>	<b>RACGP QI &amp; CPD #:</b>
<b>Languages(s) spoken other than english</b>	

### Consent to release of GP information

Primary Health Networks (PHN) collect GP information as part of the Shared Antenatal Care (SAC) program to facilitate GP participation in the program. Sydney North Health Network (SNHN) is requesting this information from you so that it can be made available to members of the public (including antenatal clinics, mothers to be and neighbouring PHNs) on its website. For the same purposes outlined above, SNHN may also provide this information to antenatal clinics and neighbouring PHNs through other mediums as needed. The Australian Privacy Principles and the Privacy Act 1988 (Cth) prohibit us from releasing this information without your consent. SNHN will not disclose your personal information to anybody else unless we are required to do so by law. Further, SNHN has a Privacy Policy that is available on its website and upon request.

PTO



**Health**  
Northern Sydney  
Local Health District



I understand that it is my choice as to what information I provide on this form. I understand that I am not obliged to provide any information requested of me, but that my failure to do so will result in SNHN being unable to provide my details for the purposes outlined above.

I have read the above information and understand the reasons for the collection of my personal information and the ways in which the information may be used and disclosed and I agree to that use and disclosure.

Name (print in block letters) \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please return to Sydney North Health Network**

**Fax: 02 8088 4770**

**email: [scollins@snhn.org.au](mailto:scollins@snhn.org.au)**

**Mail: PO Box 1083, Chatswood, 2067**