



## Agreement under section 46E(2) of the *Health Insurance Act 1973*

### Important information

By completing this Agreement, you are authorised to receive the General Practice Immunisation Incentives practice report (GPII020A) from the Australian Childhood Immunisation Register (ACIR).

This agreement is made by either 'an individual immunisation provider' or 'a medical practice' and outlines your obligations under section 46E of the *Health Insurance Act 1973* regarding the use and storage of the information contained in the report.

The GPII020A report is available to practices registered for the General Practice Immunisation Incentives (GPII) scheme or the Practice Incentives Program (PIP) and identifies the children included in your practice's GPII outcomes payment calculation.

### Assistance

If you need assistance completing this agreement or need information about the ACIR call **1800 246 101** (call charges may apply) or go to [www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au) > **For health professionals > Other programs > Australian Childhood Immunisation Register**

### Lodgement

Send the completed agreement to:

**Immunisation Section  
Medicare Australia  
GPO Box 295  
Hobart TAS 7001**

or fax to: **03 6281 0555**

Print in **BLOCK LETTERS**

Tick where applicable

### Practice/provider details

- 1** Are you:
- a Medical practice  **Go to 6**
- an Individual immunisation provider  **Go to next question**

### Individual immunisation provider

- 2** GPII/PIP practice number (if applicable)
- 3** Immunisation provider's full name
- 4** Practice address  
  
Postcode

- 5** Work phone number
- Fax number  
 **Go to 11**

### Medical practice

- 6** GPII/PIP practice number (if applicable)
- 7** Practice name
- 8** Practice address  
  
Postcode
- 9** Contact person
- 10** Work phone number
- Fax number

### Agreement and Declaration

#### 11 I understand that:

I am not in breach of this Agreement or the *Health Insurance Act 1973* if:

- I am legally required to give the identifying information to a court; or
- I am a recognised immunisation provider and give the identifying information in the course of immunising children.

#### I agree that:

even after I cease to be a recognised immunisation provider:

- I will not use the identifying information except for a purpose relating to the immunisation or health of the child; and
- I will not, either directly or indirectly, give the identifying information to another person; and
- I will protect any record of the identifying information I have against loss or misuse using security measures which are reasonable; and
- in accordance with section 130(3B) of the *Health Insurance Act 1973*, I will not use this information except for the purpose for which it was requested.

#### I declare that:

- the information on this agreement is correct.

## Individual immunisation provider

12 Provider number

Provider's full name

Provider's signature

Date

## Medical practice

This must be signed by all providers working at the practice.

13 Provider number

Provider's full name

Provider's signature

Date

14 Provider number

Provider's full name

Provider's signature

Date

15 Provider number

Provider's full name

Provider's signature

Date

16 Provider number

Provider's full name

Provider's signature

Date

17 Provider number

Provider's full name

Provider's signature

Date

18 Provider number

Provider's full name

Provider's signature

Date

19 Provider number

Provider's full name

Provider's signature


Date

20 Provider number

Provider's full name

Provider's signature

Date

 Attach an additional page if more signatures are required.

## Privacy note

The information provided on this Agreement will be used by Medicare Australia to record your acceptance of the conditions contained in the Agreement. The collection of this information is authorised by the *Health Insurance Act 1973*. This information will not be disclosed to any other third party unless authorised or required by law.