



PATIENT CONSENT FORM

FOR COLLECTION, USE & DISCLOSURE OF PERSONAL HEALTH INFORMATION

Privacy of your personal health information is an important part of our office providing you with quality dental care. We understand the importance of protecting your personal health information. We are committed to collecting, using and disclosing your personal health information responsibly. We also try to be as open and transparent as possible about the way we handle your personal health information. It is important to us to provide this service to our patients.

In this office, Dr. Wong is the contact person for personal health information related matters. All staff members who come in contact with your personal health information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

Attached to this consent form, we have outlined what our office is doing to ensure that:

- only necessary information is collected about you;
- we only share your information with your consent;
- storage, retention and destruction of your personal health information complies with existing legislation, and privacy protection protocols;
- our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law.

Do not hesitate to discuss our policies with me or any member of our office staff.

Any requests for access or correction to your personal health information should be directed, in writing, to Dr. Samantha Wong.

If you are dissatisfied with the manner in which we have addressed your requests for access or correction to your personal health information or if you have general concerns about our privacy practices, you may contact the Office of Privacy Commissioner of Ontario by:

Surface Mail:
Information and Privacy Commissioner/Ontario
2 Bloor Street East Suite 1400
Toronto, ON
M4W 1A8

Email: info@ipc.on.ca
Phone:
Toronto Area: (416) 326-3333
Long Distance: 1-800-387-0073
TDD/TTY: (416) 325-7539
Fax: (416) 325-9195

Thank you for your support and understanding in helping our office comply with all regulatory requirements and generally with the law.



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HOW OUR OFFICE COLLECTS, USES & DISCLOSES PATIENTS' PERSONAL HEALTH INFORMATION

We understand the importance of protecting your personal health information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.

This office will collect, use and disclose personal health information about you for the following purposes:

- to deliver safe and efficient patient care
- to identify and to ensure continuous high quality service
- to assess your health needs
- to provide health care
- to advise you of treatment options
- to enable us to contact you
- to establish and maintain communication with you
- to offer and provide treatment, care and services in relationship to the oral and maxillofacial complex and dental care generally
- to communicate with other treating health-care providers, including specialists and general dentists who are the referring dentists and/or peripheral dentists
- to allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments
- to allow us to efficiently follow-up for treatment, care and billing
- for teaching and demonstrating purposes on an anonymous basis
- to complete and submit dental claims for third party adjudication and payment
- to comply with legal and regulatory requirements, including the delivery of patients' charts and records to the Royal College of Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act
- to comply with agreements/undertakings entered into voluntarily by the member with the Royal College of Dental Surgeons of Ontario, including the delivery and/or review of patients' charts and records to the College in a timely fashion for regulatory and monitoring purposes
- to permit potential purchasers, practice brokers or advisors to evaluate the dental practice
- to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- to deliver your charts and records to the dentist's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- to prepare materials for the Health Professions Appeal and Review Board (HPARB)
- to invoice for goods and services
- to process credit card payments
- to collect unpaid accounts
- to assist this office to comply with all regulatory requirements



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By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal health information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal health information, we will seek your approval in advance.

Your personal health information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA.

You may withdraw your consent for use or disclosure of your personal health information at any time.

PATIENT CONSENT

I have reviewed the above information and the attachment ("How Our Office Collects, Uses and Disclose Patients' Personal Information") that explains how your office will use my personal health information, and the steps your office is taking to protect my information.

I know that your office has a Privacy Code, and I can ask to see the Code at any time.

I agree that Winona Dental, the registered business name of Dr. Samantha Wong Dentistry Professional Corporation, can collect, use and disclose personal health information about myself and my dependent children (where applicable) as set out in the information about the office's privacy policies.

Print Patient/Parent/Guardian Name:

Date:

Signature of Patient/Parent/Guardian:

Print Witness Name:

Date:

Signature of Witness:
