DRONYK
HEALTH CLINIC

Patient Privacy Consent Form

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

All staff members who come in contact with your personal 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.

In 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 information complies with legislation and privacy protocols
- Our privacy protocols comply with legislation, standards of our regulatory bodies and the law

HOW OUR OFFICE COLLECTS, USES AND DISCLOSES PATIENT'S PERSONAL INFORMATION

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined below how our office is disclosing your information. This office will collect, use and disclose 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
- To communicate with other treating health care providers, including but not limited to specialists, referring doctors, family doctors, massage therapists, naturopathic doctor
- To allow us to maintain communication and contact with you to distribute health care information 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 claims for third party adjudication and payment
- To comply with legal and regulatory requirements, including the delivery of patient's charts and records to governing bodies in a timely fashion, when required, according to the provisions for the Regulated Health Act.

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- To comply with agreements/undertakings entered into voluntarily by the member with governing bodies, including the delivery and/or review of patient's charts and records in a timely fashion for regulatory and monitoring purposes
- To permit purchasers, practice brokers or advisors to evaluate the 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 office'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
- To comply generally with the law

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 information; we will seek your approval in advance.

Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) and for the defense of a legal issue.

You may withdraw your consent for use or disclosure of your personal information and we will explain both the process and the ramifications of that withdrawal.

PATIENT CONSENT

I have reviewed the above information that explains how your office will use my personal information and the steps your office is taking to protect my information.

I agree that the Dronyk Health Clinic can collect, use and disclose personal information about:

(Patients name)_____

As outlined above regarding the privacy policies of the Dronyk Health Clinic.

Signature: _____

Print Name: _____
(Print name and relationship to patient if signing for a child under 16)

Date: _____ Signature of Witness: _____

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