Alexander
Dental Centre

PATIENT CONSENT FORM FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our office providing you with the best quality dental care. 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. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly.

We only share your information with your consent. Storage, retention and destruction of your personal 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.

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

- To deliver safe, effective and high quality patient care.
- To offer and provide advice, treatment care and services in relation to the oral and maxillofacial complex and dental care generally.
- To communicate with you and with other treating health-care providers (specialists and general dentists who are the referring dentists and/or peripheral dentists).
- To allow us to efficiently conduct the business of dentistry, including the collection of accounts and the completion and submission of dental claims for third party adjudication and payment and the processing of payments.
- For teaching and demonstrating purposes on an anonymous basis.
- To comply with agreements or undertakings entered into voluntarily by the member with the regulatory body for regulatory and monitoring purposes.
- To permit potential purchasers, practise brokers, or advisors to evaluate the dental practise.
- 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)

By signing the consent section of this Patient Consent Form, you agree to have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises or an unusual request is received, we will seek your approval in advance for permission to release such information.

Our office will not, under any conditions, supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly to you for review and for your specific consent.

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

I, _____, have reviewed the above information that explains how Dr. Corina Alexander's office will use my personal information, and steps this 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. In this office, Dr. Corina Alexander acts as the Privacy Information Officer.

_____ _____ _____

SIGNATURE DATE WITNESS

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PRINT NAME (AND RELATIONSHIP TO PATIENT)