

## The Dental Place

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### PATIENT PRIVACY CONSENT FORM FOR COLLECTION, USE & DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an essential part of our office providing you with quality 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.

In this office, the Privacy Information Office is:

#### **Dr. Prathana Davla**

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 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 & destruction of your personal information complies with existing legislation & privacy protocols.
- Our privacy protocols comply with privacy legislation, standards of our regulatory body and the law.

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

Please ensure that every staff person in our office is committed to ensuring that you receive the best quality care.

Patient/Parent/Guardian: \_\_\_\_\_.

Signature

**HOW OUR OFFICE USES THE COLLECTED PERSONAL INFORMATION:**

Our office understands the importance of protecting your personal information. Below we have outlined, how our office uses the personal information you have shared with us:

- To deliver safe and efficient patient care.
- To identify and to ensure continuous high-quality service.
- To assess your health and oral hygiene needs.
- To advise you treatment options.
  
- To enable us to contact and maintain continuous communication with you for various official and other reasons as it may be required from time to time.
- To communicate with other treating health-care providers, including specialists and referring doctors.
- To allow us to efficiently follow-up for treatment, care and billing.
- For teaching and demonstrating purpose on an anonymous basis.
- To share our latest offerings and sending in appointment reminders.
- To comply with legal and regulatory requirements, including the delivery of patient’s chart & records to governing bodies in a timely fashion, when required, according to the provisions of the Regulated Health Professional Act.
- To comply with agreements/undertaking entered into voluntarily by the member with governing bodies, including the delivery &/or review of patient’s charts and records in a timely fashion for regulatory & monitoring purposes.
- To permit/allow potential purchasers, practice brokers, advisors to audit and evaluate the office for sale or other purpose like raising additional funds etc.
- 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 and debit card payments.
- To collect unpaid accounts receivable.
- To assists this office to comply with regulatory and legal requirements.
- To comply generally with Law.

**Patient/Parent/Guardian:** \_\_\_\_\_  
**Signature**

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

Your information may be assessed by regulatory authorities under the terms of Regulated Health Professionals Act (RHPA) and for the defence of legal issues.

Our office will not disclose under any conditions your health or medical information to your insurer. In the event of such request, we will inform you and if need be, forward the information to you for review and for your specific consent. When unusual requests are received, we will contact you for your permission to release such information. We may also advise you if such a release is inappropriate.

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.

### **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 know that your office has a privacy code, and I can ask to see the code at any time.

I agree that Dr. Prathana Davla can collect, use and disclose my personal Information.

**Patient Name:** \_\_\_\_\_.

**Patient Signature:** \_\_\_\_\_.

**OR**

**Parent/Guardian Signature & Name:** \_\_\_\_\_.