XY DENTAL CLINIC PATIENT CONSENT TO THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION UNDER THE *PERSONAL INFORMATION PROTECTION AND ELECTRONIC DOCUMENTS ACT* AND THE *HEALTH INFORMATION PROTECTION ACT.*

Date:_________________________, 20____.

PRIMARY CONTACT INFORMATION:

Name:____

Address:____

____

Phone: Home:_________________________ Work:_________________________ Cell:________________________

Other:_________________________E-mail:____

Employer:____

Address of Employer:____

Social Insurance Number:____(if required)

DENTAL INSURANCE (obtain copy of Standard Claim form if available)

INSURER:
(private or government agency)

Name:____

Address:____

Phone:____

Group Policy Number:____

Certificate Number:____

ACKNOWLEDGMENT AND CONSENT

I____ acknowledge reviewing with

____, the XY Dental Clinic Privacy Policy and

I understand my rights of privacy with respect to my personal information.

I further consent to the collection, use and disclosure of my personal information for the following purposes:

(Check)

_____ To provide me with dental health services

_____ To maintain communications and provide me with information and follow up respecting my dental care;

_____ To obtain payment of your account;

_____ For the uses, purposes and disclosures described in the Privacy Policy: and

Other____

____

____

RESTRICTED ACCESS (optional)

My personal information shall not be provided to the following individuals or organizations:

____

____

____

RESTRICTED INFORMATION (optional)

Personal information disclosed from personal information collected shall not include:

____

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____

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SIGNATURE