HILLCREST CENTRE FOR HEALTH

832 St. Clair Ave W. Toronto, ON M6C 1C1 Tel: 416-651-6602 Fax: 416-651-9058

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

Privacy of your personal information is an important part of our clinic, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

Our privacy policy outlines what we are 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 existing legislation, and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy.

HOW THE CLINIC COLLECTS, USES AND DISCLOSES PATIENTS' PERSONAL INFORMATION

The clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined how we are using and disclosing your information.

The clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns
- To provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To send you newsletters and other information mailings
- To remind you of upcoming appointments
- To communicate with other treating health-care providers
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others

By signing this Patient Consent Form, you have agreed that you have given your consent to the collection, use and/or disclosure of your personal information as outlined above.

PATIENT CONSENT

I have reviewed the above information that explains how the Hillcrest Centre for Health will use my personal information, and the steps that the clinic is taking to protect my information.

I agree that the Hillcrest Centre for Health can collect, use and disclose personal information about _____as set out above in the information about the clinic's privacy policies.
(Patient Name)

_____ _____ _____

Signature Print name Date