CUMBERLAND PERIODONTICS & IMPLANT SURGERY

Patient Consent Form

In this office, Dr. Michael Goldberg is the contact person for personal health information related matters. All staff members managing personal health 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. Our office understands the importance of protecting your personal health information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.

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

- To assess your health needs and provide safe and efficient dental care.
- To enable us to contact and maintain communication with you to distribute health care
- Information and to book and confirm appointments.
- To communicate with other treating health care providers, including other dentists, physicians, pharmacists and lab technicians.
- For teaching and demonstrating purposes on an anonymous basis.
- To complete and submit dental claims for third party adjudication and payment.
- To comply with legal and regulatory requirements.
- To deliver your charts and records to the dentist's insurance carrier to enable the insurance company to assess liability and quantify damages, as necessary.
- To invoice for goods and services.
- To process credit card payments.
- To collect unpaid accounts.

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 health information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal health information, we will seek your approval in advance.
Your personal health information may be accessed by regulatory authorities under the terms of the Regulated Health

Professions Act (RHPA) for the purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA.
You may withdraw your consent for use or disclosure of your personal health information at any time.

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

I agree that Dr. Michael Goldberg and Associates can collect, use and disclose personal health information about _____as set out above in the information about the office's privacy policies.

Signature:

Print name: _____

Date: _____

Signature of witness: _____