Vcarepoint
MEDICAL

PRIVACY CONSENT FORM

Consent for Collection, Use and Disclosure of Personal Health Information

VCarepoint Medical Clinic is committed to protecting your personal health information in accordance with the Personal Health Information Protection Act, 2004 (PHIPA).

This form describes how we collect, use and disclose your personal health information and how you can access your information.

1. HOW WE COLLECT, USE AND DISCLOSE YOUR INFORMATION

We collect, use and disclose your personal health information for the following purposes:

- ☐ Assessment and treatment
- ☐ Referrals to other healthcare providers
- ☐ Laboratory and diagnostic testing
- ☐ Appointment scheduling and reminders
- ☐ Health care system administration
- ☐ Billing and payment processing
- ☐ Insurance and third-party requests
- ☐ Quality improvement and practice management
- ☐ Public health reporting as required by law
- ☐ Other purposes as permitted or required by law

2. YOUR RIGHTS

You have the right to:

- Request access to your personal health information
- Request correction of inaccurate or incomplete information
- Withdraw consent for the collection, use or disclosure of your information (subject to legal and clinical limitations)
- Receive a copy of our Privacy Policy

3. CONSENT

By signing below, you consent to VCarepoint Medical Clinic collecting, using and disclosing your personal health information for the purposes described above, in accordance with PHIPA and other applicable laws.

You may withdraw or change your consent at any time by providing written notice to the clinic.

Patient Name (Please Print): _____

Date of Birth (DD/MM/YYYY): _____

Signature of Patient (or Substitute Decision Maker): _____

Date (DD/MM/YYYY): _____

IF SIGNED BY SUBSTITUTE DECISION MAKER

Name (Print): _____

Relationship to Patient: _____

Authority to Act: ☐ Power of Attorney ☐ Committee of Person ☐ Other: _____

OFFICE USE ONLY

Staff Name (Print): _____ **Signature:** _____ **Date:** _____

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