Soni Dentistry

PATIENT CONSENT
FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal health information is an important part of providing you with quality dental care. We understand the importance of protecting your personal health information. We are committed to collecting, using and disclosing your personal health information responsibly. We also try to be as open and transparent as possible about the way we handle your personal health information. Only necessary information is collected about you. We only share your information with your consent. Storage, retention and destruction of your personal health information complies with existing legislation, and privacy protection protocols. Our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law.

In this office, Dr. Anand Soni is the contact person for personal health information related matters.

All staff members who come in contact with your 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, and answer your questions.

How Our Office Collects, Uses and Discloses Patients' Personal Information

We will only collect, use, and share the information contained in your dental records, including personal information, photos, x-rays, clinical information, and financial information, as is reasonably necessary for the following:

- To assess your oral health needs, advise you of treatment options, and deliver safe and efficient patient care
- To communicate with laboratories and other treating health-care providers, including pharmacists, specialists and general dentists who are the referring dentists and/or peripheral dentists, and doctors as it pertains to your health care
- For research, dental health promotion, education and study between colleagues and with dental patients. **Your name and contact information will remain confidential.**
- To obtain information from your dental plan insurance provider on dental coverage and benefits for the purpose of assisting you with estimates or pre-authorizations for treatment
- For the purpose of billing, submitting dental claims for third party adjudication and payment, processing credit card payments, collecting unpaid accounts and maintaining contact with our patients (booking, confirming appointments,sending gifts such as flowers)
- To permit potential purchasers, practice brokers or advisors to evaluate the dental practice to conduct an audit in preparation for a practice sale
- To deliver your charts and records to the dentist's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- To assist this office to comply with all regulatory requirements and the law (eg: lawful identification purposes)

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.

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 Soni Dentistry can collect, use and disclose personal information about _____ as set out above in the information about the office's privacy policies.

Patient Name: _____

_____

Patient Signature **Date:**

_____

Witness **Date**