**CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION AND PERSONAL HEALTH INFORMATION**

**Purposes of Collection**

I understand that my personal health information is collected and used for the purpose of:

* Providing me with the most appropriate health care
* Training and educating of future health care providers within the clinic
* Promoting interprofessional practice between Georgian College Health & Wellness Clinics (Oral Health, Optical, Massage Therapy, Acupuncture, and Speech Hearing & Language Clinics).

**Information Sharing**

I have been informed that the Georgian College Health & Wellness Clinics listed above share the same Electronic Medical Record system. I understand that **a limited amount of my personal health information which is documented in the Georgian College Clinic that I attend is visible to the other listed Georgian College Clinics, and would be seen by the staff and student(s) involved in my care should I choose to attend one of the other listed Clinics**. This limited information includes demographics (including family doctor and next of kin), and general health history such as medical conditions, surgeries, allergies, medications, etc. The shared information does NOT include appointments, treatment notes, assessments or anything else specifically related to the care I obtained at the clinic I am attending. I am aware that if I have questions and or wish to gain clarity on exactly what information is shared that I may do so with clinic staff, or contact Georgian College’s Access & Privacy Office at the email or phone number listed below.

**Privacy**

I understand that Georgian College has a legal obligation to protect patients’ right to privacy and that the collection, use and disclosure of personal health information within Georgian College Clinics is governed by the *Personal Health Information Protection Act (2004*). **I understand that my personal health information will not be shared with individuals who do not have a need to know the information.**

I have reviewed a **summary** of the Sadlon Centre for Health & Wellness Information Protection Policy and understand how the Information Protection Policy applies to me.

**Access**

I am aware that I have the right to request access to my personal health information and that I may request a correction to my information if the information is inaccurate.

**Consent**

I am aware that I can withdraw my consent for the collection, use or disclosure of my information at any time, but that this withdrawal is not retroactive.

I agree to the collection, use and disclosure of personal and health information for the purposes set out in this statement and in the Sadlon Centre for Health & Wellness (Georgian College) Information Protection Policy (the entire Policy is available to you if you wish to review it).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name (printed)**  **Patient Date of Birth (mm/dd/yy)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or Substitute Decision Maker Date (mm/dd/yy)**

**Relationship to Patient (if signing on behalf of patient):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTES MADE BY *Georgian College Clinic personnel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

|  |  |
| --- | --- |
| **Last Name:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **First Name:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  (MM/DD/YYYY) | **Gender: M or F**  *(Please Circle)* |
| **Address:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  (Street Name/#) (City) (Postal Code) | |
| **Preferred Contact Number:**  **\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_** | **Home, Cell or Work**  *(Please Circle)* |
| **Alternative Contact Number:**  **\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_** | **Home, Cell or Work**  *(Please Circle)* |
| **Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Emergency Contact: (NEXT OF KIN)**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  (Name) | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  (Contact Number) |
| **HOW DID YOU HEAR ABOUT OUR CLINIC? PLEASE CIRCLE BELOW**  **FRIENDS / FAMILY WEBSITE**  **INTERCLINIC OTHER: PLEASE SPECIFY** | |

“The students and staff of the TCM Acupuncture Clinic at Georgian College would like to thank you for your ongoing commitment to our teaching and learning environment. Your participation as a client with assessments, treatment and remedial exercises are critical in supporting students, as they develop the professional skills and expertise required in their future careers."