Embrace ORTHODONTICS

DR. KIRBY CADMAN • DR. JAMES STEPHENSON
CERTIFIED SPECIALISTS IN ORTHODONTICS

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

Privacy of your personal information is an important aspect of the provision of orthodontic care. We understand the importance of protecting your personal information, and we are committed to collection, use and disclosure of your personal information responsibly and as open and transparently as possible. It is important to us to provide this service to our patients.

In this office, Dr. Kirby Cadman and Dr. James Stephenson act as the Privacy Information Officers. All staff members who come in contact with your personal 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. Included in this consent form, we have outlined what our office is doing to ensure that:

- Only necessary information is collected about you and only shared with your consent
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocol
- Our privacy protocols comply with privacy legislation standards of our regulatory body, the College of Dental Surgeons of Saskatchewan, and the law.

HOW OUR OFFICE COLLECTS, USES AND DISCLOSES A PATIENT'S PERSONAL INFORMATION

To give you a better understanding, we have outlined below how our office is collecting, using and disclosing your information:

- To deliver safe and efficient patient care and to identify and to ensure continuous high quality service
- To assess your health needs, advise you of treatment options and to provide you with the necessary health care in relationship to the oral and maxillofacial complex
- To allow us to contact and maintain communication with you, to distribute health care information, and to book and confirm appointments
- To process payments, collect unpaid accounts, and to invoice for goods and services
- To complete dental claims for third party adjudication and payment. To comply with legal and regulatory requirements our office will not under any condition supply your insurer with your confidential medical history.
- To communicate with other treating health-care providers, including general dentists and specialists
- For teaching and demonstrating purposes on an anonymous basis
- To deliver your charts and records to the orthodontist's insurance carrier to enable the insurance company to assess liability and quantify damages, if any, including the delivery of patients' charts and records to The College of Dental Surgeons of Saskatchewan, when required, according to the provisions of the Regulated Health Professions Act.
- To comply with agreements/undertakings entered into voluntarily by the member with The College of Dental Surgeons of Saskatchewan, including the delivery and/or review of patients' charts and records to the College for regulatory and monitoring purposes.
- Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purposes of The College of Dental Surgeons of Saskatchewan fulfilling its mandate under the RHPA, and for the defense of a legal issue.
- To prepare materials for the Health Professions Appeal and Review Board (HPARB)
- To permit potential purchasers, practice brokers or advisors to evaluate and/or audit in preparation for a practice sale
- To assist this office to comply with all legal regulatory requirements

When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

Please do not hesitate to discuss our policies with any member of our staff. Be assured that every staff person in our office is committed to ensuring that you receive the best quality orthodontic care.

PATIENT CONSENT

By signing the consent section of this **Patient Consent Form**, you have agreed that you have given your informed consent to the collection, uses and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosures of your personal information, we will seek your approval in advance.

I have reviewed the outlined information that explains how your office will use my personal information, and the steps your office is taking to protect my information. I understand I may withdraw my consent for use or disclosure of any personal information, and the ramifications of that decision and the process will be explained by your office.

I agree that Drs. Kirby Cadman, Dr. James Stephenson, and their staff can collect, use and disclose personal information about (*patient's name*) _____ as set out above.

_____ _____

Signature patient/parent/guardian *Print name*

_____

Date

Restrictions

I opt to place the following restrictions on the use or distribution of my personal information to the following persons and/or organizations:

_____

_____

_____

(*signature of above patient/parent/guardian*)