Patient Privacy Consent Form

This office will collect, use and disclose information about you for the following purpose:

- To deliver safe and efficient patient care.
- To establish and maintain communication with you.
- To advise you of treatment options.
- To permit potential purchasers, practice brokers or advisors to evaluate the practice.
- To comply with agreements/undertakings entered into voluntarily by the member with governing bodies, including the delivery and/or review of patient's charts and records in a timely fashion for regulatory and monitoring purposes.
- To communicate with other treating health-care providers, including specialists and referring doctors.
- To identify and to ensure continuous high quality service.
- To allow us to efficiently follow-up for treatment, care and billing.
- To assess your health needs.
- To enable us to contact you.
- To allow us to maintain communication and contact with you to distribute heath-care information and to book and confirm appointments.
- To complete and submit claims for third party adjudication and payment.
- To provide health care.
- To offer and provide treatment, care and services.
- For teaching and demonstrating purposes on an anonymous basis.
- To comply generally with the law.
- To invoice for goods and services, process payments and collect unpaid accounts.
- To deliver your charts and records to the office'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.
- To prepare material for the Health Professions Appeal and Review Board (HPARB)

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

Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) and for the defense of a legal issue.

Our office will not under any conditions supply your insurer with confidential medical history. In the event this kind of request is made, we will forward the information directly to you for review, and for your specific consent. 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.

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 agree that **Dr. Essam Michael** can collect, use and disclose

Personal information about _____as set out above in the
(patient's name)
Information about the office's privacy policies.

Signature _____Print Name_____

Date _____Signature of Witness_____