ONTARIO HEALTH CLINICS

BRANTFORD FHO

Patient Privacy Agreement & Consent

Ontario Health Clinics Brantford FHO is committed to providing you with the best medical care possible. As part of this commitment we must collect, store and disclose your personal health information. As our patient, you should know that we handle your private information in accordance with the Personal Health Information Protection Act (PHIPA) and we have taken steps to keep your personal health information confidential and secure. A copy of our privacy statement is available upon request.

We respect your right to privacy and we ask that you recognize our right to share your personal health information with other providers involved in your care. These providers include the other health care professionals you have visited or will visited, the health testing and screening facilities have used or will use and the pharmacy or pharmacies where you have obtained or will obtain your prescription medications.

In signing this declaration you acknowledge the above. You also authorize us to collect and store your personal health information, including but not limited to all personal information contained in your medical records obtained from the pharmacy or pharmacies you use and obtained from other health testing and screening facilities and to use and/or disclose this information as follows:

- To be entered into the Ontario Health clinics Brantford FHO database in an anonymous format that will not identify you. I agree_____(initial here)
- To be shared by Ontario Health Clinics Brantford FHO in perpetuity with its health care partners so that they can learn more about the management of various states and diseases I agree_____(initial here).
- To be used to communicate with you about products, services and/or information that could be of interest to you. I agree_____(initial here)

_____ I have read and understand the above terms. I am signing for myself.

_____ I have read and understand the above terms. I am signing on behalf of a dependant.

_____ _____

Name of Patient (Please Print) Your Name (if different-Please Print)

_____ _____

Date Signature