BLUEWATER HEARING

COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Privacy of your personal health information is an important part of our office providing you with quality hearing 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. It is important to us to provide this service to our patients.

In this office, Audiologist, Nashlea Brogan, B.Sc.H., M.Sc., Au.D, 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.

Attached to this consent form, we have outlined what our office is doing to ensure that:

- 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 College of Audiologists and Speech Language Pathologists of Ontario, and the law.
- Do not hesitate to discuss our policies with me or any member of our office staff.
- How Our Office Collects, Uses and Discloses Patients' Personal Health Information

Our office understands the importance of protecting your personal health information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.

This office will collect, use and disclose personal health information about you for the following purposes:

- to deliver safe and efficient patient care
- to assess your health needs and provide health care
- to advise you of treatment options
- to enable us to contact you
- to establish and maintain communication with you
- to communicate with other treating health care providers, and family physicians
- to allow us to maintain communication and contact with you to distribute health care information and to book and confirm appointments
- to allow us to efficiently follow-up for treatment, care and billing
- for teaching and demonstrating purposes on an anonymous basis
- to complete and submit hearing related claims for third party adjudication and payment

- to comply with legal and regulatory requirements, including the delivery of patients'
- charts and records to the College of Audiologists and Speech-Language Pathologists of Ontario (CASLPO) in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act
- to comply with agreements/undertakings entered into voluntarily by the member with CASLPO, including the delivery and/or review of patients' charts and records to the College in a timely fashion for regulatory and monitoring purposes
- to permit potential advisors to evaluate the Audiology practice
- to invoice for goods and services
- to process credit card payments
- to collect unpaid accounts

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 CASLPO 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 health information, and the steps your office is taking to protect my information.

I agree that Bluewater Hearing can collect, use and disclose personal health information about

_____ as set out above in the information about the office's privacy policies.

_____ _____

Signature Date

_____ _____

Print name Signature of Witness