Appendix 3 Office privacy handout for clinic patients.

This information document outlines how we protect the privacy of your personal information and medical record at this clinic located at 320 Adelaide St S.

Everyone working for this office is required to adhere to the protections described in this policy. If you have any questions regarding our privacy practices, please contact your doctor or one of our staff.

1. **Collection, Use and Disclosure of Personal Information:** We collect the following personal information:
    a. Identification and Contact information (name, address, date of birth, emergency contact, etc.)
    b. Billing information (provincial plan and/or private insurer)
    c. Health information (symptoms, diagnosis, medical history, test results, reports and treatment, record of allergies, prescriptions, etc.)
2. **Limits on collection**
    a. We collect only the information that is required to provide care, administrate the care that is provided, and communicate with you. We do not collect any other information, or allow information to be used for other purposes, without your express (i.e., verbal or written) consent, except where authorized to do so by law.
3. **When and to whom do we disclose personal information?**
    a. **Implied consent for provision of care**: By virtue of seeking care from us, your consent is implied (i.e., assumed) for your information to be used by this office to provide you with care, and to share with other providers involved in your care.
    b. **Disclosure to other health care providers**: Relevant health information is shared with other providers involved in your care, including (but not limited to) other physicians and specialists, pharmacists, lab technicians, nutritionists, physiotherapists and occupational therapists.
    c. Disclosures authorized by law: There are limited situations where we are legally required to disclose your personal information without your consent. These situations include (but are not limited to) billing provincial health plans, reporting infectious diseases and fitness to drive, or by court order.
    d. Disclosures to all other parties: Your express consent is required before we will **disclose your information to third parties for** any purpose other than to provide you with care or unless we are authorized to do so by law. Examples of disclosures to other parties requiring your express consent include (but are not limited to) third party medical examinations, enrolment in clinical (research) trials and provision of **charts** or chart summaries to insurance companies.
    e. Can you withdraw consent? You can withdraw your consent to have your information shared with other health care providers or other parties at any time, except where the disclosure is authorized by law. However, please discuss this with your physician first.

f. **Patient Rights: How do you access the personal information held by this office?** You have the right to access your record in a timely manner. If you request a copy of your record, one will be provided to you at a reasonable cost. If you wish to view the original record, one of our staff must be present to maintain the integrity of the record, and a reasonable fee may be charged for this access. Patient requests for access to the medical record can be made verbally or in writing to the physicians or staff (see office address at top of Policy).
g. **Limitations on access:** In extremely limited circumstances you may be denied access to your records, but only if providing access would create a significant risk to you or to another person.
h. **What if you feel your record is not accurate?** We make every effort to ensure that all of your information is recorded accurately. If an inaccuracy is identified, you can request that a note be made to reflect this on your file.
i. **How secure is your information?** Safeguards are in place to protect the security of your information. These safeguards include a combination of physical, technological and administrative security measures that are appropriate to the sensitivity of the information. These safeguards are aimed at protecting personal information against loss or theft, as well as unauthorized access, disclosure, copying, use or modification.
j. **What is our communications policy?** We protect personal information regardless of the format. Specific procedures are in place for communicating by phone, email, fax, and post/courier.
k. **How long do we keep information?** We retain patient records as required by law and professional regulations.
l. **How do we dispose of information when it is no longer required?** When information is no longer required, it is destroyed in a secure manner, according to set procedures that govern the storage and destruction of personal information.
m. **Complaints process:** If you believe that this office has not replied to your access request or has not handled your personal information in a reasonable manner, please address your concerns first with your doctor.
    i. We encourage you to contact us with any questions or concerns you might have about privacy or our Privacy Policy. We will investigate and respond to your concerns about any aspect of our handling of your information.
    ii. In most cases, an issue is resolved simply by telling us about it and discussing it.

You can reach us at:
GROW Family Health
320 Adelaide St S, Unit B, London, ON
N5Z3L2

Phone number: 519-878-8621
Fax number: 519-913-4045
If, after contacting us, you feel that your concerns have not been addressed to your satisfaction, we will provide information on other complaint procedures that may be available to you.

Appendix 4: Consent to Disclose Personal Health Information
Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

I, _____ , authorize _____ to disclose:
(Print your name) (Print name of health information custodian)

□ my personal health information consisting of: (Describe the personal health information to be disclosed):

_____

or

□ the personal health information of _____
(Name of person for whom you are the SDM*)
consisting of (Describe the personal health information to be disclosed):

_____

to (Print name and address of person requiring the information):

_____

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

Name: _____

Address:

Telephone:

E-mail: _____

Signature:_____ Date:_____

Witness Name: Telephone:

Signature: Date:

*Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.