NORTH MAIN
FAMILY DENTAL

403 980 0056
office@northmainfamilydental.ca

Consent to Collect, Use and Disclose Personal Information

Purpose of Collecting Personal Information

I understand that North Main Family Dental collects personal information about me for the purposes of providing and coordinating dental care, maintaining my dental records, processing payments and insurance claims, communicating with me about appointments and treatment, and meeting legal and regulatory requirements.

The information collected may include, as applicable:

- My name, address, telephone number, email address and date of birth;
- Health and dental history;
- Information about my current medications, allergies and medical conditions;
- Dental examination findings, diagnoses, treatment plans and treatment records;
- Dental images, photographs and radiographs;
- Insurance and billing information; and
- Other information reasonably necessary to provide dental services.

Consent

I consent to the collection, use and disclosure of my personal information by North Main Family Dental for the purposes described above and for purposes that are reasonably related to my dental care and the administration of my account.

I understand that my personal information may be disclosed, when reasonably necessary, to other healthcare providers involved in my care, dental laboratories, insurers and benefit providers, payment processors, and other service providers assisting the clinic, as permitted or required by law.

Where my information is to be disclosed for a purpose that is not reasonably related to my dental care or the administration of my account, I understand that the clinic may seek my additional consent where required.

Electronic Communication

I understand that the clinic may contact me by telephone, email, text message or other electronic means regarding appointments, treatment and administrative matters. I understand that electronic communications may involve privacy and security risks.

Withdrawal of Consent

I understand that I may withdraw my consent to the collection, use or disclosure of my personal information, subject to legal or contractual restrictions and reasonable notice. I understand that withdrawing consent may affect the clinic's ability to provide certain services or communicate with me.

Questions or requests concerning my personal information may be directed to:

Privacy Contact: Dr. Richelle Bedier

Telephone: 403-980-0056

Email: office@northmainfamilydental.ca

Patient Acknowledgement

By signing below, I confirm that I have read and understood this consent and have had an opportunity to ask questions about the collection, use and disclosure of my personal information.

Patient/Authorized Representative Name:

_____

Date:

_____

Signature:

_____

If signed by an authorized representative, relationship to patient:

_____