

Consent to Collect Use, and Disclose Personal Health Information

Jinna's Acupuncture Centre, RMT #P212, R. Tcmp, R.Ac #538
287 Lakeshore Road East, Mississauga, ON L5G 1H3 / 905-990-0917

I _____, or my substitute decision-maker _____
Print name Print name if applicable

Consent Do not consent

For Jinna's Acupuncture Centre ("Clinic") to collect, use and disclose my personal health information for the purpose of providing traditional Chinese medicine, acupuncture, Tuina massage or registered massage therapy to me.

The personal health information that may be collected, used or disclosed by the Clinic may include the following, among other things:

- my birth date and contact information
- my health history and family health history
- my health status
- the health care I receive (including identifying my health care provider(s));
- my health number
- the identification of my substitute decision-maker, if any
- insurance or billing information relating to health care

I understand that there may be situations in which practitioners at the Clinic will have to collect, use or disclose personal health information without my consent, but that they will only do this if permitted by law.

How My Information Will Be Used

I understand that my personal health information may be collected, used or disclosed for the following reasons:

- To provide me with providing traditional Chinese medicine, acupuncture, Tuina massage or registered massage therapy
- To obtain payment for services provided
- To assist insurance companies with insurance claims verification
- To seek advice for potential treatment options
- To provide or arrange health care in cases of emergencies
- To fulfill any obligations as mandated by law

Patient Access to Information

I understand that my personal health information is available to me for my review except in limited circumstances as permitted by law. I also understand that I can ask to have my personal health information corrected if I believe there is a mistake in the records, with some exceptions.

Acknowledgment

I allow the Clinic to collect, use and disclose my personal health information as outlined above.

I understand that I can access my personal health information with some limited exceptions.

I understand that I am not required to sign this form and that I can withdraw my consent at any time by contacting Jinna Zheng, but it may directly affect the services I can receive. My personal health information may still be collected, used or disclosed if permitted by law.

Patient/Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____