

Consent to Collect and Release Information  
TG Wellness Clinic

I, \_\_\_\_\_ or my appointed representative \_\_\_\_\_,

Consent       Do not consent

For TG Wellness Clinic to collect and release my general patient or medical information to other medical practitioners or health care providers/support workers, emergency personnel and/or any other relevant organizations.

In terms of information, the Clinic may collect any of the following:

- Contact information
- Personal or family medical history
- Medical insurance or billing/account information

In cases of emergencies or life threatening situations, medical or support staff workers may have to collect this information from family members or other listed contacts without your prior written consent.

**How Your Information Will Be Used**

Your personal information can be used or disclosed for the following reasons:

- For billing or account purposes
- To assist 3<sup>rd</sup> party insurance companies with insurance claims
- Referring your medical history to another health practitioner or health care provider
- To seek advice for potential treatment options
- To prevent or assist patients in cases of emergencies or threat to their health and safety
- To fulfill any obligations as mandated by law

**Patient Access to Information**

I understand that my personal and medical history is available to me for my review under most circumstances. Cases where access to records can be limited are:

- In cases where access to information causes a threat to your life or personal health
- Where the law disallows access to information
- In the event where disclosure of information relates to any anticipated or actual legal proceedings or professional conduct proceedings.

**Acknowledgment**

I allow for medical personnel to use and disclose my information as outlined above.

I understand that I can access my personal health information except as outlined above.

I understand that I can withdraw my consent at any time, but it may directly affect the services I can receive. My personal information can still be used/disclosed if mandated by law.

Additional Comments/Restrictions	
Patient Signature:	Date:
Witnessed:	Date: