Dr. Gerry Pochynok
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CONSENT TO COLLECT, USE AND DISCLOSE PERSONAL HEALTH INFORMATION

(in accordance with PIPEDA "personal information protection and electronic documents act")

I authorize Dr. Gerry Pochynok, to collect personal information relating to my child's dental and medical health. This information is required to allow proper evaluation, diagnosis and treatment of oral and dental health conditions.

I consent to communication of this information to my referring dentist, other dental specialists, my physician(s), surgical centres, dental laboratories and/or my insurance carrier if necessary. Information may be transferred to the necessary individuals by mail, phone, fax or email.

This information may include clinical records, x-rays, study models, photographs of my child's teeth/mouth/smile/face, general health information obtained from a medical history review, insurance information and phone numbers/addresses. Clinical information and photographs/x-rays may also be used for long-term follow-up and research purposes, as well as for education or teaching purposes.

This office recognizes the importance of personal information protection and makes every effort possible to safe-guard this information.

I certify that I have read and understand this document.

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SIGNATURE OF PARENT OR GUARDIAN *DATE*

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PRINTED NAME OF PARENT OR GUARDIAN