Privacy Consent Form

As a patient of Dr Joel Rhee's practice, we require your consent to collect, use and disclose relevant information about you for the primary purpose of providing quality healthcare.

Please complete and sign below:

I consent to the collection, use and disclosure of relevant personal information as outlined in the Practice's Privacy Policy	◯ YES ◯ NO
I consent to receiving telephone, e-mail and/or SMS appointment reminders	◯ YES ◯ NO

I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Signature: _____ Date: _____

Patient name (please print): _____

If the patient is unable to sign due to lack of capacity to make and/or communicate decisions about their healthcare:

Person responsible name (please print): _____

Relationship to the patient (please print): _____