SOLIS MEDICAL CLINIC
HELPING YOU CREATE BETTER HEALTH

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# TEXT REMINDER CONFIRMATION FORM

**We invite you to participate in our online system. Please confirm your information.**

**CURRENT INFORMATION** **CORRECTIONS, IF ANY**

**Name** _____

**Address 1** _____

**Address 2** _____

**City** _____

**Province** _____

**Postal Code** _____

**Home Phone** _____

**Cell Phone** _____

**Email ID** _____

**How would you like to be NOTIFIED (CIRCLE what is applicable): TEXT or EMAIL**

We use this information to provide you with excellent care. Our clinic respects your confidentiality and privacy. When you receive health services from our clinic, we will collect individually identifying health information in accordance with the provisions of the Health Information Act (HIA). We will collect this health information directly from you, except in the limited circumstances when we are authorized under HIA to indirectly collect such information.

Our primary purpose in collecting your health information is to provide diagnostic, treatment, and care services to you, determine or verify your eligibility for health services, bill the Alberta Health Care Insurance Plan for our services, and provide for health services provider education. Our clinic will only collect, use, and disclose your health information in accordance with the provisions of HIA. We will also protect your health information from unauthorized access, use, disclosure, or destruction per the privacy provisions of this legislation.

I agree to allow Solis Medical Clinic to use this information in providing my services.

I_____authorize any information pertaining to my medical history to be transferred by fax transmission.

Signature:_____Date: