SANDRA GABRIELE, RD
Registered Dietitian
3095 Glen Erin Drive, Suite #4
Mississauga, ON L5L 1J3

HEALTH CONSENT FORM

Consent for Cost of My Services:
$125.00 per hour for new assessments and $65 per half hour for follow up appointments, payable at the time of the appointment. A fee will be charged for missed appointments or cancellations with less than 24 hours notice.

Consent for Personal Information:
I accept that it will be necessary for *Sandra Gabriele, RD* to collect personal, health and lifestyle information, e.g. home telephone, address, way of eating, etc.

Use, Disclosure, and Retention of Information
I understand that only information relevant to the provision of services for my medical/nutritional management will be collected, and that this information will be retained for ten years following the last date of service or ten years following my eighteenth birthday, whichever is longer. I agree to the disclosure of my contact information when payment for nutrition therapy is not received in full.

I give permission for this information to be shared with (name and address):

____

____

Access to Information
I understand that I may review the information in my file for accuracy and currency. If I disagree with the information, I accept that either a correction will be made or my disagreement will also be noted.

I understand that I may review the Privacy Policy of *Sandra Gabriele, RD* so I can fully understand how it applies to me. I know that at any time I may ask questions about the Privacy Policy, and have them answered to my satisfaction. This is available to me at any time.

I agree to *Sandra Gabriele, RD* collecting, using and disclosing my personal information as set out above and in the Privacy Policy of *Sandra Gabriele, RD.*

Email Communication
I acknowledge that if I initiate e-mail or text communication with *Sandra Gabriele, RD* I have consented to e-mail/text communication. I understand the risks to my personal information and limitations of e-mail/text communication. *Sandra Gabriele, RD* will not initiate e-mail/text communication without my explicit consent. I can withdraw consent to e-mail/text communication at any time.

____
Date

____ ____
Signature of Patient or Substitute Decision Maker (SDM) **Printed Name** of Patient or SDM

January, 2020