Date:_____

To: Dr. Lenkinski, Dr. Tam, Dr. Khurana

CONSENT

I have reviewed your office privacy policy, dated January 1, 2004, and I consent to your collection, of any and all personal information about me including my personal health information, and all personal information about any minor of whom I have joint or sole parental custody, and to use such information in any manner or for any purpose whatsoever, but only in the course, of, concerning, or relation to, your dental practice, the *Endodontic Specialty Group*. I similarly consent to the disclosure to third parties of all such information but only in accordance with the Regulated Health Professions, the Dentistry, and Dental Hygiene Acts of Ontario, and to any insurer or other payment organization who may be responsible for payment of all or a part of any treatment or service you provide.

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