



Patient Consent for Assessor Observation

The purpose of this form is to obtain your consent for one or more assessors selected by the College of Physicians and Surgeons of Ontario (the “**College**”) to observe a health care provider perform a procedure on you at the facility known as

(the “**Facility**”).

About the College

The College regulates the practice of medicine to protect the public. One of the College’s roles is to conduct quality assurance assessments of Independent Health Facilities at the request of the Ministry of Health and Long-Term Care (the “**Ministry**”).

Facility Assessment

The Facility is an Independent Health Facility licensed by the Ministry. The Ministry has requested that the College conduct a quality assurance assessment of the Facility.

What you are consenting to

The College is asking your permission to conduct the following activities:

1. Observe a health care provider providing treatment to you or performing a procedure on you during your visit to the Facility.
2. Collect and use information from the observation for purposes of an assessment under the *Independent Health Facilities Act*, including reporting to the Ministry; and
3. Use the information from the observation, which may include information that identifies you, in other College investigations or proceedings if necessary.

The assessment team includes Dr. _____ and
_____ (technologist).

Information relating to consent

The College will limit the use and disclosure of the information to the purposes set out above, and to what is required or permitted by law. The College's use and disclosure of information is subject to various confidentiality protections, including section 36 of the *Regulated Health Professions Act*, section 37 of the *Independent Health Facilities Act*, and the College's Privacy Code.

If you have any questions about this consent, please email ihf@cpso.on.ca for assistance.

Please sign in the space below to show you have read the consent and have had the opportunity to ask questions about it. Your signature indicates that you understand the nature of the consent and give your consent for the College activities described above.

Print name clearly

Signature

Date

Date of Birth (dd/mm/yyyy)

_____ explained and received this consent on _____
(Name) (Date)