***Please complete the bolded areas but leave the remainder of the form blank (including the dates) as this will be completed at the time of submission by our staff.**

Ontario

Ministry of Health and Long-Term Care

Microfilm use only

Patient Enrolment and Consent to Release Personal Health Information

oint pen.

Collection of the information on this form is under the authority of the *Ministry of Health Act*, subsection 6(1) and (2) and the *Health Insurance Act*, R.S.O. 1990, c. H.6, s.4(2)(b) and (f), 4.1(1) and (2), 10 and 11(1). For information about collection practices, contact the Director, Registration and Claims Branch, Box 48, 49 Place d'Armes, Kingston ON K7L 5J3, INFOline tel. 1 888 218–9929 or by mail through the addresses listed for local Ministry of Health and Long-Term Care offices.

Section 1 - I want to enrol myself with the family doctor identified in Section 4

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

Send notices from my family doctor's office to me by:
☐ regular mail ☐ email *(if possible)*

Email Address:

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery | City/Town | Postal Code

Residence Address ▶ or ☐ same as Mailing Address | Apartment # | Street No. and Name or Lot, Concession and Township | City/Town | Postal Code

Section 2 - I want to enrol my child(ren) under 16 and/or dependent adult(s) with the family doctor identified in Section 4

A

Last Name (Person you are signing for) | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

Mailing Address ▶ or ☐ same as Section 1 | Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery | City/Town | Postal Code

Residence Address ▶ or ☐ same as Section 1 | Apartment # | Street No. and Name or Lot, Concession and Township | City/Town | Postal Code

B

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

Mailing Address ▶ or ☐ same as Section 1 | Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery | City/Town | Postal Code

Residence Address ▶ or ☐ same as Section 1 | Apartment # | Street No. and Name or Lot, Concession and Township | City/Town | Postal Code

Section 3 - Signature

I have read and agree to the Patient Commitment, the Consent to Release Personal Health Information and the Cancellation Conditions on the back of this form. I acknowledge that this Enrolment is not intended to be a legally binding contract and is not intended to give rise to any new legal obligations between my family doctor, and me.

I am signing on behalf of *(check all that apply)*
☐ myself ☐ child(ren) ☐ dependent adult(s)

My Name
last name | first name

Signature
X

Date *(yyyy/mm/dd)*
(Please leave blank)

Home Telephone No.
( )

Work Telephone No.
( )

Section 4 - Family doctor Information

☐Dr. Jessica Bodig (017886)
☐Dr. Allison Clarke (019748)
☐Dr. Andrea DiPaolo (019750)
☐Dr. Philippe Pinard (027026)

510 Raglan Street North, Renfrew, ON, K7V1P5
Ancient Rivers FHO

(Include Billing no. and Group no.)

Family Doctor's Signature
X

Date *(yyyy/mm/dd)*

PHYSICIAN COPY

Patient Enrolment and Consent to Release Personal Health Information

Patient Commitment

I agree to contact my family doctor, (or if applicable the group to which my family doctor belongs or the designated Telephone Health Advisory Service if available to me), when I, or my enrolled child(ren) or dependent adult(s), need primary care medical advice or treatment. I promise to do this unless there is an emergency or I am travelling away from home.

I agree that if I or the person(s) I have signed for move, I will contact my family doctor's office or the ministry (see box below) with a new address and telephone number.

I understand that I can end my enrolment with this family doctor and enrol with another family doctor after six weeks have passed from the date that I complete and sign this form (immediately if I have moved). However, I agree not to change the doctor with whom I am enrolled more than twice a year.

I understand that by enrolling a child under 16 or a dependent adult, my signature on the front of this form means that I agree to these terms and conditions on behalf of that person. When an enrolled child reaches 16 years of age, the ministry will contact him or her to confirm enrolment/consent with the family doctor.

Consent to Release Personal Health Information

I understand that my family doctor will be able to offer better medical care if I permit my family doctor and the ministry to share appropriate and relevant information relating to my health.

I agree to allow my family doctor, other family doctors in the Patient Enrolment Model (if applicable) and the ministry to exchange the information in this form related to my enrolment.

I agree that my family doctor and the ministry can exchange information about my name, address and telephone number.

I agree to allow the ministry to release the following specific information to my family doctor:

- dates of immunizations (flu shots, etc.)
- dates of preventive care screening services (pap tests, mammograms, etc.)
- dates of service, fees paid and fee codes of primary health care services provided to me by a family doctor outside my family doctor's Patient Enrolment Model (if applicable).

If the Telephone Health Advisory Service is available to me, I agree to allow my family doctor and the ministry to exchange only the following information with the designated Telephone Health Advisory Service: my name, health number and version code, address, date of birth, gender.

I understand that this consent to release personal health information ends when:

- My enrolment with my family doctor ends or
- I cancel my consent by writing or telephoning the Ministry of Health and Long-Term Care (see box below).

The ministry will inform my family doctor when the consent is no longer valid. However, I understand that the information already released to my family doctor will remain in my medical file.

Cancellation Conditions

Enrolment with my family doctor and my consent to release personal health information will end when:

a) I cancel my enrolment by writing my family doctor or by writing or telephoning the ministry *(see box below);*
b) I no longer qualify for health care services under the *Health Insurance Act (Ontario);*
c) the Patient Enrolment Model to which my doctor belongs no longer exists;
d) my family doctor chooses to discontinue acting as my family doctor in accordance with the College of Physicians and Surgeons of Ontario guidelines;
e) I enrol with another family doctor; or
f) the ministry grants me an extended absence.

My enrolment with my family doctor and my consent to release personal health information may end when:

a) I consistently fail to meet the obligations to which I agreed in the Patient Commitment *(above);*
b) my family doctor leaves this Patient Enrolment Model;
c) I become a resident of a long-term care facility;
d) I am imprisoned in a provincial or federal correctional institution; or
e) I move outside the geographic area where the Patient Enrolment Model to which my family doctor belongs regularly provides services.

Contact Information:

Ministry of Health and Long-Term Care
P.O. Box 48, Station Main
Kingston ON K7L 9Z9

Call: INFOline 1 888 218–9929
TTY 1 800 387–5559

(Cette formule est aussi disponible en format bilingue. Pour recevoir une copie, composez : 1 888 218–9929)

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