Ontario Ministry of Health

Patient Enrolment and Consent to Release Personal Health Information

Microfilm use only

Please PRINT using black or blue ballpoint pen.

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

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

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

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

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

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)*

Home Telephone No.
( )

Work Telephone No.
( )

Section 4 – Family doctor information

PG15836
DR. NICOLE CARPE
TWO RIVERS FHO
B10-350 CONESTOGA BLVD
CAMBRIDGE ON N7R7L7

BILLING NO. 041018 GROUP NO. BABX

(Include Billing no. and Group no.)

Family Doctor's Signature
X

Date *(yyyy/mm/dd)*

4383–80 (2006/04)

PHYSICIAN COPY

Ontario

Ministry of Health
and Long-Term Care

Primary Health Care New Patient Declaration

Do not mail this form to the ministry. This form must remain in the physician's office for audit purposes.

Please complete this form if you are a new patient of a primary care physician and have signed a Patient Enrolment and Consent to Release Personal Health Information form. If you are signing on behalf of a child or dependent adult, and have completed a Patient Enrolment and Consent to Release Personal Health Information form on their behalf, complete the applicable sections below.

Declaration

I am signing on behalf of *(check the applicable boxes)*

- ☐ myself *(complete sections A and C)*
- ☐ the children listed below of whom I am the parent or guardian *(complete sections B and C)*
- ☐ the dependent adult (s) listed below for whom I have a power of attorney for personal care *(complete sections B and C)*

I hereby declare that the patient(s) named below does/do not have a family physician due to one or more of the following circumstances: *(check applicable boxes)*

- ☐ The patient's family physician has moved to another community.
- ☐ The patient has moved to another community.
- ☐ The patient's physician is no longer available due to illness/death/retirement.
- ☐ The patient's physician is no longer available due to change of practice type.
- ☐ Up until now the patient has not had, or felt the need for a family physician.

Section A: Patient Information

First Name	Last Name	Health Number

Section B: Children and Dependent Adults

	First Name	Last Name	Health Number
1.			
2.			

For additional children / dependent adults, please complete another New Patient Declaration form.

Section C: Signature and Date

Signature	Date

Section D: Physician Signature and Date

I declare that the above patient is not presently a patient of mine or, to the best of my knowledge, of any other physician in the primary care group with which I am affiliated (if applicable). I also declare that no child listed (if any) is a newborn of any existing enrolled or non-enrolled patient of mine, or to the best of my knowledge, of any other physician in the primary care group with which I am affiliated (if applicable).

I agree to accept the above-noted patient(s) into my practice and to provide ongoing health care to the patient(s) from the date of this document. I will keep this document available on file in my primary office location and will provide copies to the Ministry of Health and Long-Term Care as required for verification purposes.

Physician Last Name *(print)*	First Name *(print)*
CARPE	NICOLE

Physician Signature	Date

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
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)

4383–80 (2006/04)