

## Ministry of Health and Long-Term Care

# Patient Enrolment and Consent to Release Personal Health Information

One form per adult patient. Photocopy for additional adult family members.

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.

Microfilm use only

addresses listed for local Ministry of Health and Long-Term Care offices.	,	,	, g		
Section 1 – I want to enrol myself with the			Section 4		
Last Name	First Nam	е	Second Name		
Health Number Versi		Apartment #	Street No. and Name or	P.O. Box, Rura	l Route, General Delivery
	Address ▶				
Date of Birth (yyyy/mm/dd) Sex		City/Town			Postal Code
, , , ,   M [	]F				
Send notices from my family doctor's office to me by:	Residence	Apartment #	Street No. and Name of	r Lot, Concessi	<u> </u>
	Address >	'			•
regular mail email (if possible) Email Address:	or	City/Town			Postal Code
Endi Addiess.	same as mailing	J.,			
	address				
Section 2 – I want to enrol my child(ren) un			lult(s) with the fam		entified in Section 4
Last Name	First Nam	е		Second Name	
Health Number Versi		Apartment #	Street No. and Name or	P.O. Box, Rura	l Route, General Delivery
	Address				
Date of Birth (yyyy/mm/dd) Sex	or same as	City/Town			Postal Code
_ , , ,   ,   _ M [	F Section 1				
I am this person's	Residence	Apartment #	Street No. and Name of	r Lot, Concessi	on and Township
parent	Address <b>&gt;</b>				
legal guardian	or	City/Town			Postal Code
attorney for personal care	same as Section 1				
Last Name	First Nam	<u>l</u> e		Second Name	
В					
Health Number Versi	on <b>Mailing</b>	Anartment #	Street No. and Name or	PO Box Bura	I Route, General Delivery
Code	Address >	/ partirioni //	Oncervo. and vame of	1 .O. DOX, 1 lara	ir route, deficial belivery
Date of Birth (vvvv/mm/dd) Sex	or	City/Tourn			Postal Code
	same as	City/Town			Postal Code
		A in a interes a int #	Chroat No. and Norse	ul at Camanasi	an and Taumahin
I am this person's parent	Residence Address	Apartment #	Street No. and Name of	r Lot, Concessi	on and Township
legal guardian		Ott./T			I De stal Ocala
attorney for personal care	or same as	City/Town			Postal Code
	Section 1				
Section 3 – Signature		Section 4 – Family doctor information			
I have read and agree to the Patient Commitment, the C Personal Health Information and the Cancellation Condit					
this form. I acknowledge that this Enrolment is not intended to be a binding contract and is not intended to give rise to any new legal		DR. GORICA MILOJEVIC			
obligations between my family doctor, Group, and me.	ew iegai	BILLING NO. 032034			
I am signing on behalf of (check all that apply)		- BILLING NO. 002007			
myself child(ren) dependent adult(s)		FHO GROUP NO. BARC			
My Name		1	211001 110. D/ II (		
last name first nam	е				
Signature Date (yyyy/mm/dd)		(Include Billing no. and Group no.)  Signature on behalf of Group  Date (yyyy/mm/dd)			
	yyy/11111//UU/	"	i benan of Group		Date (yyyy/IIIII/dd)
X		X			Dilli N
Home Telephone No. Work Telephone	No.	Office use Or	nly <i>(print)</i>		Billing Number
( )					

### 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;
- 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;
- 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)