Ontario **Ministry of Health** **Ministère de la Santé**

Patient Enrolment and Consent to Release Personal Health Information

You are being asked to enrol with a primary health care **Group**. A primary health care group is a group of family doctors and other health care providers who are working together to give you and your family continued access to quality primary care services.

Enrolling with a primary health care group is your choice. If you choose to enrol, please fill out this form **using a black or blue ball point pen** as follows:

- To enrol **yourself** . . . . . *complete* ***Sections 1 & 3***
- To enrol **yourself** and up to **two** children under 16 years of age and/or dependent adults for whom you are a parent, legal guardian or attorney for personal care . . . . . *complete* ***Sections 1, 2 & 3***
- To enrol children under 16 years of age and/or dependent adults for whom you are a parent, legal guardian or attorney for personal care but **not** yourself . . . . . *complete* ***Sections 2 & 3***
- To enrol **more than two** children under 16 years of age or dependent adults for whom you are a parent, legal guardian or attorney for personal care . . . . . *complete* ***Sections 2 & 3*** *on a separate form*

Note: If the mailing address includes a post office box (P.O. Box), rural route (R.R.), or general delivery, you must also complete the residence address.

If your primary health care group is not already identified or is incorrectly identified in Section 4, please print the name of the Group inside the box in Section 4.

Your Group will acknowledge your enrolment form in Section 4 and will provide you with a copy for your records.

For questions about enrolment and consent, filling out this form or to receive additional forms, please call INFOline at 1 888 218–9929 (TTY 1 800 387–5559).

Vous êtes invité à vous inscrire auprès d'un **Groupe de soins de santé primaires (Groupe)**.
Un groupe de soins de santé primaires est un groupe de médecins de famille ou d'autres fournisseurs de soins de santé qui travaillent ensemble pour vous assurer, à vous et aux vôtres, un accès continu à des services de soins de santé primaires de qualité.

L'inscription auprès d'un groupe de soins de santé primaires est facultative. Si vous décidez de vous inscrire, veuillez remplir le présent formulaire ***(servez-vous d'un stylo à bille à encre bleue ou noire)*** comme suit :

- Pour **vous** inscrire . . . . . *remplissez les* ***Parties 1 et 3***
- Pour **vous** inscrire et inscrire **un** ou **deux** enfants de moins de 16 ans et/ou des adultes à charge dont vous êtes parent, tuteur légal ou procureur aux soins de la personne . . . . . *remplissez les* ***Parties 1, 2 et 3***
- Pour inscrire des enfants de moins de 16 ans et/ou des adultes à charge dont vous êtes parent, tuteur légal ou procureur aux soins de la personne, mais **sans** vous inscrire vous-même . . . . . *remplissez les* ***Parties 2 et 3***
- Pour inscrire **plus de deux** enfants de moins de 16 ans ou des adultes à charge dont vous êtes parent, tuteur légal ou procureur aux soins de la personne . . . . . *remplissez les* ***Parties 2 et 3*** *sur un formulaire distinct*

Remarque : Si votre adresse postale est une case postale (CP), une route rurale (RR) ou la poste restante (PR), vous devez également remplir la section de l'adresse du domicile.

Si votre groupe de soins de santé primaires n'est pas déjà identifié ou l'est incorrectement à la Partie 4, veuillez écrire son nom en caractères d'imprimerie dans la case prévue à cette fin à la même Partie.

Votre Groupe accusera réception de votre formulaire d'inscription en remplissant la Partie 4 et il vous en remettra une copie pour vos dossiers.

Si vous avez des questions au sujet de l'inscription et du consentement, ou si vous voulez savoir comment remplir le formulaire ou en obtenir des exemplaires supplémentaires, veuillez appeler la Ligne INFO au 1 888 218–9929 (ATS : 1 800 387–5559).

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Please see reverse for more instructions.
Veuillez consulter l'endos pour de plus amples directives.

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Ontario

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.

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

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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