

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		Mailing Address	
Date of Birth (yyyy/mm/dd)		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Apartment # Street No. and Name or P.O. Box, Rural Route, General Delivery	
Send notices from my family doctor's office to me by: <input type="checkbox"/> regular mail <input type="checkbox"/> email (if possible)		Residence Address		City/Town Postal Code	
Email Address:		or same as mailing address <input type="checkbox"/>		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		First Name		Second Name	
Health Number		Version Code		Mailing Address	
Date of Birth (yyyy/mm/dd)		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Apartment # Street No. and Name or P.O. Box, Rural Route, General Delivery	
I am this person's <input type="checkbox"/> parent <input type="checkbox"/> legal guardian <input type="checkbox"/> attorney for personal care		Residence Address		City/Town Postal Code	
		or same as Section 1 <input type="checkbox"/>		City/Town Postal Code	

B Last Name		First Name		Second Name	
Health Number		Version Code		Mailing Address	
Date of Birth (yyyy/mm/dd)		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Apartment # Street No. and Name or P.O. Box, Rural Route, General Delivery	
I am this person's <input type="checkbox"/> parent <input type="checkbox"/> legal guardian <input type="checkbox"/> attorney for personal care		Residence Address		City/Town Postal Code	
		or same as Section 1 <input type="checkbox"/>		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 Date (yyyy/mm/dd)

X

Home Telephone No.

()

Work Telephone No.

()

Section 4 Family doctor information

Family Doctor's Signature

X

Date (yyyy/mm/dd)