

Ministry of Health and Long-Term Care

Patient Enrolment and Consent to Release Personal Health Information

Microfilm	use	only

Please PRINT using black or blue ballpoint 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 addresses listed for local Ministry of Health and Long-Term Care offices.

addresses listed for local Ministry of Health and Long-Term Care offices.			Armes, Kingston ON K7L 5J3,	INFOline tel. 1 888 218	3-9929 or by mail through the	
Last Name	lly doctor id	entified in	Section 4	March College	16 To 10 To 10 To 10	
Last Name	First Nam	First Name			Second Name	
Health Number Version		·	province and the second second			
Health Number Version Code	Mailing Address		Street No. and Name o	r P.O. Box, Rural	Route, General Delivery	
Date of Birth (yyyy/mm/dd) Sex	- Addioss p					
Date of Birth (yyyy/mm/dd) Sex		City/Town			Postal Code	
			(* 			
Send notices from my family doctor's office to me by:	Residence Address	Apartment #	Street No. and Name of	or Lot, Concession	n and Township	
regular mail email (if possible) Email Address;	or					
andi Addiosoj	same as mailing	City/Town			Postal Code	
	address	SVIII A SOO K S AT SANSAN OWN				
Section 2.— I want to enrol my child(ren) under	First Nam	pendentac	luli(s) with the fam	ily doctor ide	ntiffed in Section 4	
	riist ivaiii	U		Second Name		
Health Number Version	Malling	[A				
Code	Address >	Apartment #	Street No. and Name o	r P.O. Box, Rural	Route, General Delivery	
Date of Birth (yyyy/mm/dd) Sex	or	City/Town			T	
M	Same as	City/ fown			Postal Code	
l am this person's		Apartment #	Stroot No. and No.			
□ parent	Residence Address		Street No. and Name of	r Lot, Concession	and Township	
legal guardian	or	City/Town			Pagtal Carl	
attorney for personal care	same as	- Angrica Mil			Postal Code	
Last Name	First Name	е		Second Name		
	0.50	•		Second Ivanie		
Health Number Version	Mailing	Apartment #	Street No. and Name or	DO Boy Dural	Pouls Constal D	
Code	Address >		Stroot 140, and 14amo of	r.o. box, nuralin	noute, General Delivery	
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	same as Section 1	=11400mm			Postal Code	
I am this person's	Residence	Apartment #	Street No. and Name o	r Lot Concession	and Township	
☐ parent	Address D	CANCEL STATE OF THE STATE OF TH	- Contract C	1 201, 00110033101	and rownship	
U legal guardian	or	City/Town			Postal Code	
attorney for personal care	same as Section 1					
Section 3 – Signature		Seallon	- Family decion in	io menone		
I have read and agree to the Patient Commitment, the Conser Personal Health Information and the Cancellation Conditions of this form. Lacknowledge that this Forement is a condition of the conditions of the cond	it to Release	The state of the s		arkidari Making	Manager of the second of the s	
		PG06574				
binding contract and is not intended to give rise to any new leg between my family doctor and me.	gai obligations	DR. MARIA VALENTE				
I am signing on behalf of (check all that apply)		HARBOURVIEW FHO				
myself child(ren) dependent adult(1040 OLIVER RD SUITE 301				
My Name	***************************************	I	301 DER BAY, ON P7B	7 / 5		
list name		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	JEN DAT, ON P/B	1 MD		
Signature Date (yyyy/n	nm/dd)	BILLIN	G NO. 122481 GF	ROUP NO. BA	KK	
X	·		11			
			(Include Billing	no, and Group no	o.)	
Home Telephone No. Work Telephone No.		Family Doctor	S Sidna Marda		Data Annuale	
Home Telephone No. () Work Telephone No.	1	Family Docto	MINNE	\(\frac{1}{2}\)	Date (yyyy/mm/dd)	