Ontario Ministry of Health and Long-Term Care

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Patient Enrolment and Consent to Release Personal Health Information

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

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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 ▶ or ☐ same as mailing address — Apartment # | Street No. and Name or Lot, Concession and Township | 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

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's ☐ parent ☐ legal guardian ☐ attorney for personal care

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

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

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

Residence Address ▶ or ☐ same as Section 1 — Apartment # | Street No. and Name or Lot, Concession and Township | 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 **X** | Date *(yyyy/mm/dd)*

Home Telephone No. ( ) | Work Telephone No. ( )

Section 4 Family doctor information

Dr. Lloyd Mai
Citrus Medical FHO
605 Royal York Road
Etobicoke ON M8Y 4G5

Billing Number: 045459
Group Number: BAH5

Family Doctor's Signature **X**

Date *(yyyy/mm/dd)* 2024/11/29

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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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CITRUS MEDICAL CENTRE

Citrus Medical Clinic Policies

We’re thrilled to welcome you to Citrus Medical and are committed to providing you with convenient, comprehensive, and personalized care. As you settle into our practice, we’d like to share a few details to help you make the most of your experience with us.

Booking Appointments

Our **online booking system**, Health Myself is the most convenient way to schedule your appointments. Through this system that is available 24/7, you can easily book, reschedule, or cancel appointments at your convenience. The availability you see online reflects the exact same options our staff can access, including same-day appointments. Visit our website at www.citrusmedical.ca to book your next appointment today!

- [ ] I have read and acknowledged the above.

Cancellation and No-Show Policy

To ensure fair access to our physicians, we kindly ask for at least **24 hours**' notice if you need to cancel or reschedule an appointment. Missed appointments or late cancellations will incur a **no-show fee of $40 + HST**, as these slots could otherwise be used to care for other patients. This policy helps us maintain availability for those who need timely medical attention.

- [ ] I have read and agree to the above.

Contacting the Clinic

The online contact form on our website is the most secure way to reach us. By entering your health card information, your request will be tagged directly to your chart for efficient handling. You can also upload attachments through this form, and messages can be directed to your family doctor as needed. We aim to respond to all inquiries **within 24-48 hours**, ensuring prompt attention to your needs.

Our phone lines are open during regular business hours, but please note that we receive a high volume of calls during peak hours, particularly midday and early afternoon. You can also leave us a voicemail, and all messages will be responded to **within 24 hours**.

- [ ] I have read and acknowledged the above.

How the Clinic will Contact You

With your consent, our clinic may use email to communicate important updates. By providing your email address, you agree to receive the following types of communications:

1. Appointment reminders.
2. Emails from clinic staff, which may include personal health information (e.g., name, date of birth, medical updates) such as notices of specialist appointments, requests to book appointments, or administrative updates.
3. Emails from physicians, which may include personal health information such as requisitions, test results, or other medical updates.
4. Important clinic updates, including policy changes, availability of flu shots, new doctors and services, health tips, and upcoming workshops or webinars.

There have been known issues in the past where important communications from us have ended up in spam or junk folders. Please take a moment to add the following email addresses to your safe sender list: info@citrusmedical.ca, no-reply@citrusmedical.ca

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Please note, we do not accept incoming emails from patients. If you wish to contact us via written digital communication, you can submit a request through our Contact Form at www.citrusmedical.ca

☐ I have read and acknowledged the above.

Respectful Environment Policy
At Citrus Medical, we are committed to fostering a safe and respectful environment for all patients, staff, and physicians. We have a **zero-tolerance policy** for abusive language or behavior. Ensuring a positive atmosphere is vital to delivering the best care and service to everyone.

☐ I have read and agree to the above.

Parking Information - Royal York
Please note that parking in the back of the clinic is reserved for staff only. However, free parking is available on the side streets surrounding the clinic, making it easy for you to visit us.

☐ I have read and acknowledged the above.

We're excited to have you join the Citrus Medical community and look forward to providing you with exceptional care. Should you have any questions or need assistance, don't hesitate to reach out!

Sincerely,
Citrus Medical

www.citrusmedical.ca
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2240 Lake Shore Blvd W, Toronto ON M8V 0B1
Phone: 416-800-6500
Fax: 416-342-1790