Ontario Ministry of Health

Authorization and Consent

Purpose

The purpose of this form is to collect necessary information to obtain authorized consent and assure identity, under the *Freedom of Information and Protection of Privacy Act (FIPPA)*, for application of services delivered by the Ministry of Health on your behalf (or for a "Health Care Group" in which you are a registered member), including:

- Application for an OHIP Billing Number
- Changes to Health Care Group Registration Information

Fields marked with an asterisk (*) are mandatory.

You are filling out a responsive form, where available options may change based on previous responses

What is the purpose of this Authorization and Consent Form? *

Section 1. Applicant Information

Consent for Application for an OHIP Billing Number

Last Name *	First Name *
Date of Birth (yyyy/mm/dd) *	Type of Current Certificate of Registration *
Effective Date of Current Certificate (yyyy/mm/dd) *	Current Registration Number Issued by Governing Body *

Authorization and Consent to Update Health Care Group Information

Last Name *	First Name *
Date of Birth (yyyy/mm/dd) *	Telephone Number * Extension

OHIP Billing Number

Section 2. Declaration

I declare the information provided to be true and I consent to allow the Ministry of Health to verify, with other sources, all information I have provided in this application. These sources may include, but are not limited to, the Governing Body of my related Health Profession (e.g. College of Physicians and Surgeons of Ontario, College of Midwives of Ontario) and the medical school(s) and hospitals indicated in my application.

	Date (yyyy/mm/dd) *

For more information, or if you have any questions about this application, please contact the ministry's Service Support Centre by email: SSContactCentre.MOH@Ontario.ca or by calling 1-800-262-6524.

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