Ontario

Ministry of Health
OHIP, Pharmaceuticals and Devices Division

Consent Form for the Inherited Metabolic Diseases (IMD) Program

Instructions

Please complete this form and upload to SADIE as an attachment to IMD Program Application.

You may apply for benefits under the IMD program if:

- You are, or the person in respect of who you are submitting the consent form (the "Patient") is, an Ontario resident insured under the Ontario health Insurance Plan (OHIP), and
- The Patient does not have private or employer sponsored insurance coverage in respect of the services and benefits funded by the Ministry under the IMD program.

Declaration

By signing this IMD Program Consent form I confirm that:

- I am applying to receive the services and benefits funded by the Ministry under the IMD Program (the "Program Benefits");
- I do not have private or employer-sponsored insurance coverage in respect of the Program Benefits;
- the information provided in the Application is true, accurate and complete to the best of my knowledge;
- I understand that I must immediately notify the Ministry in writing of any changes to the information I have provided in the Application, including any relevant changes in respect of coverage for Program Benefits under a private or employer-sponsored health insurance plan;
- I understand that the Ministry may collect, use and disclose the personal health information provided in the Application, in addition to such further information the Ministry may collect from other sources, for the purpose of verifying my eligibility, reimbursing claims for payment from service providers, and administering the IMD Program; and
- I understand that, from time to time, the Ministry may effect changes to the IMD Program including, without limitation, eligibility requirements and Program Benefits.

The collection, use and disclosure of personal health information by the Ministry of Health in connection with the Inherited Metabolic Diseases Program is authorized under the *Personal Health Information Protection Act*, 2004, S.O. 2004, c.3 Sched. A. The Ministry's Statement of Information Practices may be accessed at www.health.gov.on.ca. For more information, write to the Director, Delivery and Eligibility Review Branch, Ministry of Health, 5700 Yonge Street, 3rd Floor, Toronto ON M2M 4K5, telephone no. 416-327-8109 or toll free 1-866-811-9893.

	Date (yyyy/mm/dd)

* If the Patient is less than 16 years of age, the Declaration must be signed by a parent or legal guardian.

If the signature above is not that of the patient, print the signatory's information below, and attach supporting documents, as appropriate:

Last Name	First Name	Identity of Signatory* (see below)

* Categories for signatory identification:

1. Guardian of the Person (attach supporting documentation)
2. Attorney for Personal Care (attach supporting documentation)
3. Representative appointed by Consent and Capacity Board (attach supporting documentation)
4. Spouse/Partner
5. Parent
6. Other relative (specify)

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