Dr. Tim Nicholas
15017 Yonge Street
Suite # 201
Aurora, ON
L4G 1M5

May 11th, 2020

Dear Patient,

With mixed emotions, I wish to inform you that I will be retiring June 1st, 2020.

I feel very fortunate in finding Dr. Salimpour to take over my practice. Dr. Salimpour has previously been a Family Practitioner in Saskatchewan. Since migrating to Ontario he has developed a further expertise in chronic pain management. It is very gratifying to have found such a caring and competent doctor. Dr. Salimpour will begin working June 1st, 2020.

Your medical records will automatically remain with Dr. Salimpour. I am attaching a roster form for you to sign. Please drop it into the office or email it to drnicholasaurora@hotmail.ca

I will miss my patients and friends as I've truly enjoyed practising medicine. I wish you all the best and a healthy life.

Sincerely,

Dr. T. Nicholas, M.D.

Ministry of Health
and Long-Term Care

Microfilm use only

Patient Enrolment and Consent to Release Personal Health Information

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 (l), 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. 1 888 218–3929 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

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

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

Send notices from my family doctor's office to me by:
☐ regular mail ☐ email *(if possible)*

Email Address:

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

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

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

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

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

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

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

Signature
X

Date *(yyyy/mm/dd)*

Home Telephone No. ( )

Work Telephone No. ( )

Section 4 – Family doctor information

Dr. Vahid Salimpour

Billing #: 032236

SouthLake FHO - BABG
Suite # 201, 15017 Yonge Street,
Aurora- ON-
L4G 1M5

(Include Billing no. and Group no.)

Family Doctor's Signature
X

Date *(yyyy/mm/dd)*

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