Ontario Health

Client Information Form (CIF)

Date:

Completion Instructions

- **Fill out this form electronically by entering your information directly into each applicable field.**
- **Complete all fields as specified (indicate "N/A" if a field is not applicable).**
- **Once completed, save the completed CIF to your desktop and email a copy to your Ontario Health contact.**
- **If your organization is a Family Health Team, Family Health Group, Family Health Organization, or Family Health Network, provide the name of the organization used in the applicable funding agreement with the Ministry of Health.**
- **If you are a sole practitioner operating your practice as a medical professional corporation, you may choose to provide either: (i) the corporation name (in the manner set out in your Certificate of Authorization); or (ii) your own name (with your CPSO number), as the organization name when completing the CIF.**
- **If you are a home and community care service provider, provide the name of the organization used in the applicable funding agreement or contract with the Local Health Information Network (LHIN) or Ministry of Health under the Home Care and Community Services Act, 1994.**

1) Name of Organization:

Organization Name (see note above re sole practice):	
Name change or restructuring in the last eight years?	**Yes** ☐ **No** ☐
For name change, provide previous name:	
For organization restructuring, provide summary of structure change (*e.g., merger or acquisition*):	
Local Health Integration Network (LHIN):	Enter LHIN
Is your organization a member of an Ontario Health Team? (Specify all affiliations)	

2) Address of Organization:

Building Address (*number and street name*):		**Suite Number (*if applicable*):**	
Building Name (*for multi-building sites*):			
City/Town:		**Postal Code:**	
Phone Number:		**Extension:**	
Email Address:			

3) Is the organization identified above in Section 1 a health information custodian (HIC) within the meaning of the *Personal Health Information Protection Act, 2004 (PHIPA)?*

Note: As defined in PHIPA, a HIC is an individual or organization who has custody or control of personal health information as a result of or in connection with performing their powers or duties in health care. A HIC operates under its own authority and controls who may access and use personal health information in its custody (organization types below). For example, an individual operating as a sole physician or sole nurse practitioner, who controls access and use of their patients' health records is a HIC; however a physician or nurse practitioner working for an organization, such as a family heath team or hospital, or providing services to any organization under locum, is not a HIC, as the organization they work for controls access to and use of those patient health records.

☐ **Yes, a HIC** ☐ **No, not a HIC**

Indicate the applicable organization type below (select only one):

Ambulance Service	☐	**Pharmacy - Accreditation#:**	☐	**Family Health Team**	☐
Aboriginal Health Access Centre	☐	**Public Hospital**	☐	**Family Health Group**	☐
A centre, program or service for community health or mental health	☐	**Private Hospital**	☐	**Family Health Organization**	☐
Service provider under the *Home Care and Community Services Act*	☐	**Public Health Unit**	☐	**Family Health Network**	☐
Community Health Centre	☐	**Retirement Home licensed under the *Retirement Homes Act*, 2010**	☐	**Midwifery Practice/Clinic**	☐
Designated Psychiatric Facility under the *Mental Health Act*	☐	**Long–Term Care Home under the *Long Term Care Homes Act*, 2007**	☐	**Sole Physician or Physician Group Practice**	☐
Independent Health Facility as licensed under the *Independent Health Facilities Act*	☐	**NPAO listed Nurse Practitioner Led Clinic**	☐	**Walk-in clinic**	☐
Oncology Centre	☐	**Sole Nurse Practitioners and Nurse Practitioners in a Group Practice**	☐		
Other (*specify*): ☐					

***Note:** for regulated health professionals in private/community practice not addressed above indicate "Other" and provide the type of practice*

If the organization identified in Section 1 above has more than one facility or location, or operates within or is affiliated with another organization (e.g. you operate a practice from a hospital, or you are affiliated with FHT, FHO or FHG), list all below:

Facility/location or other organization name	Address	Is this facility/ location a separate legal entity?	Is this facility/ location a separate health information custodian (HIC)?
		Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐	Yes ☐ No ☐

***Note:** If any facilities, locations or organizations listed above are separate health information custodians (HIC)s, a separate CIF and agreement may be required for each.*

4) Legal status of the organization identified in Section 1 above (*check all that apply*):

Registered under the *Business Names Act* (Ontario)	☐
Partnership under the *Partnerships Act* (Ontario)	☐
Limited partnership under the *Limited Partnerships Act* (Ontario)	☐
Corporation under the *Business Corporations Act* (Ontario)	☐
Corporation under the *Corporations Act* (Ontario)	☐
Corporation under the *Not-for-profit Corporations Act* (Ontario)	☐
Health Professional Corporation under the *Business Corporations Act* (Ontario)	☐
No legal status	☐
Created under statute (*specify e.g. Public Hospitals Act*)	
Other (*specify*):	

5) Signing Authority (*person with authority to sign on behalf of the organization identified in Section 1 above*):

First Name:		**Last Name:**	
Title:			
Email Address:			

If the organization identified in Section 1 above requires two Signing Authorities to bind the organization, provide the second Signing Authority's information when submitting this CIF.

6) Authorized Representative (*contact for notice on agreement-related matters*):

First Name:			**Last Name:**	
Title:				
Phone Number:		Ext.	**Fax Number:**	
Email Address:				

7) Privacy Officer or delegate (*contact for notices on privacy matters*):

First Name:			**Last Name:**	
Title:				
Phone Number:		Ext.	**Fax Number:**	
Email Address:				
Privacy Officer Address (*if different from above*):				

8) Security Officer or delegate (*contact for notices on security matters*):

First Name:			**Last Name:**	
Title:				
Phone Number:		Ext.	**Fax Number:**	
Email Address:				
Security Officer Address (*if different from above*):				

9) Local Help Desk (if applicable) (*contact for notices on planned or unplanned system outages and upgrades and provides tier 1 technical support to the organization's employees)*

First Name:			**Last Name:**	
Title:				
Phone Number:		Ext.	**Fax Number:**	
Email Address:				

10) Notification Contacts *(contact for notices on planned or unplanned system outages and upgrades. An organization may add or change notification contacts at any time by calling 1-866-250-1554):*

First Name:			**Last Name:**	
Title:				
Phone Number:		Ext.	**Fax Number:**	
Email Address:				

First Name:			**Last Name:**	
Title:				
Phone Number:		Ext.	**Fax Number:**	
Email Address:				