I understand:

- That the disclosure of my personal health information will continue until I withdraw my consent;
- This consent will remain in effect until it is withdrawn, and that if the consent is withdrawn, this will affect eligibility under the Program;
- That the Ministry of Health will collect, use and disclose my personal health information as permitted or required by the *Personal Health Information Protection Act*, 2004;
- That I can withdraw my consent at any time by completing the Ontario Seniors Dental Care Program Change of Information Form (5128-20E); and
- That my withdrawal will have no effect on the personal health information collected by the Ministry of Health before the date of my withdrawal.

If you consent to the collection, use and disclosure of your personal health information as described on this Form, please complete and sign below.

I consent to the collection, uses and disclosures of my personal health information described in this form.

I have the legal authority to consent to this disclosure as I am: *

- [x] The Program applicant
- [ ] The Substitute Decision Maker of the Program applicant. (including the individual's attorney under a power of attorney for personal care; or the individual's guardian of the person, or the individual's guardian of property). You must attach a copy of the legal document that authorizes you to act on their behalf.

Name of Substitute Decision Maker

Relationship to Applicant	Contact Telephone Number
Signature of Applicant or Substitute Decision Maker	Date (yyyy/mm/dd) * 2019/12/19