Block access to my personal information gathered by any provincial program or service provider.

If you complete this form, you will block your personal information gathered by healthcare professionals and pharma services, disability support services, children's aid society, workplace safety and income benefits, guaranteed annual income supplement, rent supplement programs and any other provincial program or provincially funded program or service provider that gathers information from you from disseminating information collected to any other individual or agency for any purpose except with express written consent that identifies what information that will be shared and why.

These instructions are pursuant to privacy laws, common law right to privacy and the protection of security of person in the Canadian Bill of Rights.

This notice is to be given to the service provider that collects the information (any entity that collects your private data) and you may provide a copy to any specific agency that wish to prevent from sharing your information, including the premier's office.

On entry to a hospital should they require any drug history information, or your doctors records they need to have you sign a release. If you are incapacitated your family or Power of Attorney for Personal Care may sign the release.

You or your substitute decision making can unblock access to any information referred to in this document by providing notice of a reversal of your decision to block contained in this form.

BLOCKING ACCESS TO MY PERSONAL INFORMATION GATHERED BY ANY PROVINCIAL PROGRAM OR PROVINCIALLY FUNDED PROGRAM OR SERVICE PROVIDER

1. Applicant Information

Complete the following information. If hand-filling, please print using a black or blue ballpoint pen.

Fields marked with an asterisk (*) are mandatory.

Last Name *	First Name *	Middle Initial

Health Card Number*	Sex	Date of Birth * (yyyy/mm/dd)	Language Preference
	☐ Male ☐ Female		☐ English ☐ French

Current Address

Unit Number	Street Number *	Street Name *	PO Box

City/Town *	Province *	Postal Code *	Telephone Number *

2. Signature

_____ (name of person or agency gathering personal information) is hereby being notified that I am instructing that I am blocking all information gathered from me by health care professionals and pharma services, disability support services, children's aid society, workplace safety and income benefits, guaranteed annual income supplement, rent supplement programs and any other provincial program, provincially funded program or service provider that gathers information from me from disseminating the information collected from me or about me to any other individual or agency for any purpose except where the individual or agency identifies what information that will be shared, where it will be shared and why and has my express written consent.

Your signature or your substitute decision-maker's signature *	Date (yyyy/mm/dd) *
X	

Last Name	First Name

Identity of Substitute Decision-Maker (check one)

- ☐ Guardian of the Person (attach supporting documentation)
- ☐ Attorney for Personal Care (attach supporting documentation)
- ☐ Representative appointed by Consent and Capacity Board (attach supporting documentation)
- ☐ Spouse/Partner
- ☐ Parent Child
- ☐ Sibling (specify) _____
- ☐ Other relative (specify) _____

Submit to the office of _____
Name of office/entity receiving this form

Are you or your agency a member of the World Economic Forum? ☐ Yes or ☐ No

I require that the office of _____ acknowledge via email or regular mail within
Name of office/entity receiving this form

_____ of receiving this notice that they will not continue to share personal information with any other
response date (typically 14 days)
individual or agencies other than the ones that did collect the information directly from me.

File #