Ontario

Ministry of Health and Long-Term Care

33 King St W
PO Box 645
Oshawa ON L1H 8X1

Healthy Smiles Ontario
Authorizing or Cancelling a Representative

Ministry Use Only – Date Received

Please check one of the following

◯ Authorize a representative, as shown in Section 2 below. An authorization is valid until the applicant cancels it.

◯ Cancel the existing authorization of the representative shown in Section 2 below.

Fields marked with an asterisk (*) are mandatory. Complete all required information to avoid processing delays.

Section 1 Applicant Information

Complete if you are a parent/guardian who applied on behalf of your child/youth, or a youth who applied on your own behalf.

Last Name*

First Name* Date of Birth* (YYYY/MM/DD)

Unit/Apt/Suite Street Number and Name (PO Box, Rural Route, Postal Station)*

City/Town* Province Postal Code*

Section 2 Representative Information

Complete this section to authorize or cancel a representative to deal with Program registration and eligibility matters.

Last Name* First Name*

Unit/Apt/Suite Street Number and Name (PO Box, Rural Route, Postal Station)*

City/Town* Province Postal Code*

Telephone Number* Alternate Telephone Number *(optional)*

Check the applicable years(s) for which this applies: *

◯ All benefit years

◯ Only the benefit year indicated here:

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Section 3 Authorization

This section requires the applicant or spouse/common law partner to sign the consent.

I authorize the Ministry of Health and Long-Term Care, Ontario Ministry of Finance, and ServiceOntario to collect personal information from, and disclose my personal information to, the above stated representative, in matters pertaining to the Healthy Smiles Ontario Program registration and eligibility (except where my signature is required).

OR

I cancel the authorization that was previously given, as selected above; and I consent to the use and sharing of my personal information as set out below.

X Signature

Date (YYYY/MM/DD)

Section 4 Acceptance of Authorization

This section requires the representative to sign the consent.

I accept the above authorization and consent to the use and sharing of my personal information as set out below.

X Signature of Representative

Date (YYYY/MM/DD)

Notice of Collection: The personal information collected on this form will be used by the Ontario Ministry of Health and Long-Term Care, Ontario Ministry of Finance, and ServiceOntario for the purpose of determining eligibility under the Healthy Smiles Ontario Program (the "Program") and otherwise administering the Program. The Ontario Ministry of Finance's authority to collect and share personal information with the Ministry of Health and Long-Term Care and ServiceOntario is in section 11 of the *Ministry of Revenue Act* which authorizes the Ontario Ministry of Finance to assist other ministries in administering a government assistance program. The personal information collected on this form will only be used and disclosed for the purpose of administering the Program, or otherwise in accordance with applicable law. For more information about this collection, please contact the Director, Public Health Planning and Liaison Branch, Ministry of Health and Long-Term Care, 393 University Avenue, 21 Floor, Toronto ON M7A 2S1 or call 416 314-2257.