



CONSENT TO DISCLOSURE OF INFORMATION

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Employment and Assistance Act* and the *Employment and Assistance for Persons with Disabilities Act*. The collection, use and disclosure of personal information is subject to the provisions of the *Freedom of Information and Protection of Privacy Act*. You have the right to revoke this consent at any time. Any questions regarding this form should be directed to your local Employment and Assistance office.

CLIENT NAME		BIRTH DATE	
SR NUMBER (IF APPLICABLE)		CASE NUMBER (IF APPLICABLE)	

I consent to the disclosure of any personal information currently held under the custody and control of the Ministry of Social Development and Social Innovation subject to the following limitations:

1. The following specific information only. (If more space is required, please attach an additional page)
2. All information relevant to the determination of eligibility for:
- | | |
|--|--|
| <input type="checkbox"/> Income Assistance | <input type="checkbox"/> Hardship Assistance |
| <input type="checkbox"/> Disability Assistance | <input type="checkbox"/> Supplements |

This information may be disclosed to an agency and/or an individual:

AGENCY NAME		INDIVIDUAL NAME	
ADDRESS			
CITY / TOWN	POSTAL CODE	TELEPHONE NUMBER	FAX NUMBER
AGENCY NAME		INDIVIDUAL NAME	
ADDRESS			
CITY / TOWN	POSTAL CODE	TELEPHONE NUMBER	FAX NUMBER

This consent is effective on the date it is signed and will remain valid until I request that it be cancelled.

SIGNATURE OF PERSON GIVING CONSENT	DATE (YYYY MMM DD)
NOTE: If you are signing on behalf of the Ministry Client, you must attach proof of that legal authority (for example, a copy of the court order naming you as Committee) to this Consent.	