

REFUSAL OF CONSENT FOR ALL MEMORY, COGNITIVE AND DEMENTIA TESTING

_____ Date

By way of this letter, in keeping with my rights under the *Health Care Consent Act of Ontario, 1996*, and until further written notice, I am formally **Refusing Consent** to mental, memory, cognitive or dementia testing, particularly if it in any way is connected, directly or indirectly, to driver licensing or driver testing, and especially if the results of any such testing or examining are being appraised, evaluated, or compared by a non healthcare and/or non-licensed healthcare professional.

I do not agree to medical testing or medical evaluation of any kind as a means of assessing my ability to drive safely.

Any person collecting, giving medical exams or evaluating information on my medical status and who gains knowledge, or who in any way interprets the results of any medical testing as reflective of my driving ability, or who reveals such information without my written authorization to release such information, or who makes a decision on my driving ability based in whole, or in part, on such medical testing, is in violation of my Constitutional Rights and Freedoms, including the right to be free from discrimination.

In addition, ALL releases of my medical condition(s) and status, are to be preceded by obtaining MY written authorization for each individual release. I reserve the right to refuse to release my medical information for any purpose associated with my driver's license and/or my driving ability.

Further, any person not duly qualified, certified and licensed as a healthcare

professional in the province of Ontario to provide medical testing and especially dementia, cognitive and mental health testing, would be subject to prosecution for practicing medicine without a license. This would apply to those who offer assessments of my driving ability as a result of having received medical information from healthcare professionals who released my medical information without my prior written authorization and/or after being subjected to medical testing of any kind for any purpose, including driving ability, for which I was not FULLY informed and for which I did not give FULLY informed consent prior to testing.

TAKE NOTICE:

This refusal to consent to any mental, memory, cognitive or dementia testing by you, your organization, your staff or contractors is effective immediately until further written notice from me.

_____ Print Name

_____ Signature & Date

address:

phone:

MAKE TWO COPIES: PROVIDE ONE TO THE DOCTOR'S OFFICE AND PREFERABLY TO THE DOCTOR HIMSELF. Have the recipient sign below and keep this copy!

Received: _____

Signature of representative & date received