



MANITOBA DENTAL ASSOCIATION

CONSENT FOR RELEASE OF INFORMATION

(Complete only if answer to Practice Information is “yes”.)

CONSENT FOR RELEASE OF INFORMATION

I have made application with the Alberta Dental Association and College for registration and licensure in order to engage in the practice of dentistry in the Province of Alberta.

I, therefore, hereby irrevocably authorize and direct the:

Manitoba Dental Association
1735 Corydon Avenue
Suite 202
Winnipeg, Manitoba R3N 0K4

Phone: (204) 988-5300

Fax: (204) 988-5310

Email: office@manitobadentist.ca

to provide the Alberta Dental Association and College with full disclosure of any and all information you may have respecting my professional conduct, competence and capacity including providing a copy of any written information in my file pertaining to these matters and this shall be your full, final and irrevocable authority for so doing.

I have received legal advice as I deemed appropriate prior to signing this consent for you to release information. I understand the legal implications and approve your release of any information to the Alberta Dental Association and College requests.

Signature of Applicant

Signature of Witness

Applicant – Please print

Witness – Please print

Date

Please return completed form marked “Confidential” to the registrar of the MDA.