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 **College of Dental Surgeons of Alberta** 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 **College of Dental Surgeons of Alberta** 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 **College of Dental Surgeons of Alberta** 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.