MANITOBA DENTAL ASSOCIATION
202 – 1735 Corydon Avenue, Winnipeg, Manitoba R3N 0K4

**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 Saskatchewan for registration and licensure in order to engage in the practice of dentistry in the Province of Saskatchewan.

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 Saskatchewan 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 the College of Dental Surgeons of Saskatchewan 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.