MANITOBA DENTAL ASSOCIATION

CONSENT FOR RELEASE OF INFORMATION

I have made application for registration and/or licensure in order to engage in the practice of dentistry

in _____.

I, therefore, hereby irrevocably authorize and direct the Manitoba Dental Association to provide to:

_____

Name of Regulatory Authority

_____

Full mailing address

With full disclosure of any 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 authorize you to speak with the Association directly to clarify or obtain further information about me. 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 above named regulatory authority requests.

_____ _____

Signature of Applicant **Signature of Witness**

_____ _____

Applicant Name – Please print **Witness Name – Please print**

_____

Date

#202 – 1735 Corydon Avenue, Winnipeg, Manitoba R3N 0K4 Phone: (204) 988-5300 Fax: (204) 988-5310 www.ManitobaDentist.ca