COLLEGE OF DENTURISTS OF ONTARIO

Consent to Release Personal Health Information Form

Declaration

Candidate's Name (Print)

Date of Birth (mm/dd/yyyy)

I authorize the disclosure of my personal health information to the College of Denturists of Ontario, 175 Bloor Street East, Suite 601, North Tower, M4W 3R8 for the purposes related to the Qualifying Examination.

Signature

Signature

Date

Please return this form to the College by email at: exams@denturists-cdo.com