COLLEGE OF DENTURISTS OF ONTARIO

Consent for Release of Personal Heath Information

I, _____, (Date of Birth: _____, _____, _____)
DAY MONTH YEAR

authorize the disclosure of my personal health information to the College of Denturists of Ontario, 365 Bloor Street East, Suite 1606, Toronto, Ontario, M4W 3L4 for the purposes related to the Qualifying Examinations.

SIGNED BY: _____

(CANDIDATE NAME)

DATED: _____