



**Authorization to Release Information**

.....  
 Surname

.....  
 Given Name

.....  
 Former Name(s)

Address: .....

Street	City	
.....		
Province	Postal Code	Country

**To Whom It May Concern**

I, ....., understand that the College of Dental Hygienists of Ontario, and authorized persons acting on its behalf, may contact any educational institution; assessment, examination or credentialing agency; previous or present employers; or governing or regulatory body to obtain information which would assist the College in determining whether I am eligible to be registered as a dental hygienist in Ontario.

I hereby give my consent to any institution, agency, employer or governing or regulatory body to release such information upon request of the College of Dental Hygienists of Ontario which may in any way be relevant to my application.

.....  
 Applicant's Signature Date