



Patient Information Release Form

Recently a denturist provided services to you. As part of their professional obligation, the denturist collected personal information and recorded the treatment and your visits.

The denturist wishes to submit copies of your patient record to comply with the internship portfolio requirements of the College of Denturists of British Columbia. In British Columbia an individual or corporation may, by law, only use your personal information for the purpose for which it was collected. As submission of your record, to demonstrate a regulatory requirement, may not have been anticipated, the denturist is requesting your authorization to submit the record to the College of Denturists of British Columbia.

Your information will be protected at all times and used solely for the purpose of determining whether the denturist has completed the requirements of the Internship portfolio. Your record will be shredded as soon as the College completes the assessment process. The original record will remain with the denturist at all times.

Thank you for your cooperation.

Jennifer Roff
Registrar

I, _____ authorize the release of a copy of my
Print name
patient record to the College of Denturists of British Columbia for the
purpose of the Internship Portfolio.

#101-309 Sixth Street
New Westminster
British Columbia
V3L 4L8
TEL: (604) 515-0533
FAX: (604) 515-0534
www.cd.bc.ca

Signature

Date