

In accordance with *The Medical Act* the College of Physicians and Surgeons of Manitoba ("the College") maintains confidentiality with respect to applicant information, except insofar as is necessary for the College to administer the registration process or for other purposes identified in *The Medical Act*.

An applicant's prospective employer (e.g. Regional Health Authority or private medical clinic) recruiting the applicant, or another third party such as the Regional Health Authorities of Manitoba (RHAM) may seek information about the application status or the results of all or parts of the College's registration review process. Subject to the College's overriding authority to release information as necessary to administer the registration process or as permitted in *The Medical Act*, the applicant has the right to determine the extent to which the College is authorized to release information to third parties. We therefore require you to complete and return this authorization form specifying the information you are authorizing the College to release, and the third parties that may receive this information. Please be sure to sign and date the form and insert the name of all the individual(s) or organization(s) to whom you are authorizing the College to release information.

Please note that the authorization is only revocable by written, signed and dated instructions from you. ***If at any time you wish to revoke the authorization that you have given to the College, please contact the College immediately.***

The choices you make with respect to release of information to third parties will not in any way impact upon the processing of your application for registration with the College.

### **AUTHORIZATION FOR RELEASE OF INFORMATION**

TO: College of Physicians and Surgeons of Manitoba  
1000 – 1661 Portage Avenue  
Winnipeg, MB R3J 3T7  
Telephone 204 774 74344; Fax 204 774 0750

You are hereby authorized to release to \_\_\_\_\_

Any and all information respecting the status of my application for registration with the College, including the results of any and all checks, examinations and assessments relevant to my application.

**OR**

Information respecting the following specific issues relevant to my application for registration with the College. **Check off items you agree to release:**

- Medical Council of Canada examination(s) results
- EICS verification
- criminal record check results
- Family Practice Assessment or NRSAP results
- evidence of good standing
- evidence of postgraduate clinical training
- confirmation of current and previous employment

**OR**

I do not consent to the release of any information to a third party.

This authorization shall continue until revoked by me, in writing.

Signed by me at the City of \_\_\_\_\_, in \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Print Name