

AUTHORIZATION FOR RELEASE OF INFORMATION

(Please Print clearly)

I, _____, request my:

(Please check all that apply:)

- Medical or Dental School
 Internship, Residency, or Fellowship Training Program
 Attending Dentist/Physician
 Other

to verify completion of education or previous training or practice privileges as an attending dentist/physician to The University of Rochester Strong Memorial Hospital.

I also authorize the University of Rochester to contact the ECFMG to obtain a status report of ECFMG certification (if applicable) and to request copies of records or receive any other information that, in the judgment of the School, is needed to verify the successful completion of my education or previous training.

Signature

Date