UC DAVIS HEALTH | SCHOOL OF MEDICINE
Registrar's Office

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GRADUATE Authorization for Release of Information

Name: _____ / _____ / _____ Class of: _____
Last First MI

E-mail: _____ Last 4 SSN: _____

Date of Request: _____ Phone #: _____-_____-_____

I request the following record(s):

_____

_____

_____

_____

_____

_____

be sent to (please print):

1. Name: _____
   Institution: _____
   Address: _____
   City/State/Zip: _____
   Fax or Email: _____
2. Name: _____
   Institution: _____
   Address: _____
   City/State/Zip: _____
   Fax or Email: _____

I hereby consent to the disclosure, inspection and copying of information, records, and documents relating to my credentials, qualifications, education, and performance by UC Davis School of Medicine for the purpose of degree verification, licensure, credentialing, staff appointment, and clinical privileges.

Student Signature: _____ Date: _____

Office Use Only

Request processed and record(s) sent:

By: _____ Date: _____ Notes: _____