Authorization to Release Information
By Mayo Clinic School of Graduate Medical Education

I understand and acknowledge that my education records are protected under the Federal and State laws. As an applicant for medical licensing, it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my relevant training, current competence, health status, character, ethics and any other criteria adopted by state licensing board(s) or verification service companies requesting such information.

I hereby authorize Mayo Clinic School of Graduate Medical Education to release to any state licensing board(s) or verification service companies' information, records, transcripts, and other documents concerning my professional qualifications, credentials, clinical competence, ethics, character and other information reasonably having a bearing on my qualification for medical licensure.

I understand that I may revoke this consent at any time by giving written notice to:

Mayo Clinic School of Graduate Medical Education
Attn: Registrar
200 First Street SW, Siebens 5
Rochester, MN 55905

Dated: _____ _____
Signature

Printed Name:_____