Dear University of California Davis (UCD Anesthesiology & Pain Medicine Program)

Please consider this letter to be my official request that you or your designee(s) provide information regarding my residency/fellowship at UCD to the following persons/ institutions:

_____

_____

[insert contact name(s)/position(s)/institution(s) and contact information in request]

I hereby consent to the release of information as described above. I understand, however, that you reserve the right to decline to provide any information which is privileged, confidential, medical review information, proprietary, trade secret or otherwise legally protected under federal or California law. Further, I hereby agree to indemnify, and, for myself or anyone who may claim by or through me, forever waive, release and discharge and hold harmless University of California, Davis or any such entities' respective affiliates, subsidiaries, directors, officers, employees, contractors and agents (including without limitation you or your designee) from and against and with respect to any and all claims, demands, actions, causes, damages, fines, penalties, expenses (including attorneys' fees and court costs) or other losses, whether arising at law or equity, known or unknown, suspected or unsuspected, based upon, relating to, arising out of or in any way connected with the release of information permitted herein or your (or your designee's) failure or refusal to release any such information.

Print Name: _____

Signature: _____

Date: _____