UC DAVIS HEALTH | SCHOOL OF MEDICINE

Registrar's Office

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GRADUATE Authorization for Release of Information

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Name: ______________________ / ________________________ / __________ Date of Request: _________________
Last First MI

Class of: ________ Last 4 SSN: ________ Date of Birth (MM/DD/YYYY): ___________Phone #: _____-______-_______

E-mail: ______________________________

I request the following record(s):

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To be sent by (select one) mail ______email _____ to:

Name: ____

Institution: ____

Address: ____

City/State/Zip: ____

Email: ____

Or:

I Request my records be uploaded to the DOCS Portal for California Postgraduate Training License (PTL) application:
Select all that apply: Form MED _______ Copy of Certified Diploma ______
Please include your **application and/or file number** so that we can locate your record: ___________________________

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.

Signature: ____ Date: __________________________

Office Use Only

Request processed and record(s) sent:

By: ____________ Date: ____________ Notes: ____