University of California, Davis
School of Medicine, Registrar's Office

GRADUATE Authorization For Release of Information

4610 X Street, Suite 1208, Sacramento CA 95817-2200 / Phone: (916) 734-4027 / Fax: (916) 734-2178

GRADUATE- Authorization for Release of Information

Name: _____ Date of request: _____

Last 4 SSN: _____ Phone : _____

Class of: _____ e-mail: _____

I request that the following record(s):

_____

_____

_____

_____

be sent to (please print name and address):

_____

_____

_____

_____

_____

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: _____

Fax completed form to: (916) 734-2178 or email to: hs-studentrecords@ucdavis.edu

OFFICE USE ONLY

Request processed and record(s) sent:

By: _____ Date: _____

Notes: _____

Graduate Authorization for Release of Information