COLLEGE OF MEDICINE

THE UNIVERSITY OF TOLEDO

College of Medicine
Graduate Medical Education

Education Commission for Foreign Medical Graduates
Authorization for Release of Information

I hereby authorize the Educational Commission of Foreign Medical Graduates (ECFMG) to disclose to the Graduate Medical Education office at The University of Toledo certification information about me in the form of a Status Report.

I understand that the purpose of this disclosure is to validate my files in the Graduate Medical Education office.

______________________________	______________________________
Printed Name of Physician	ECFMG #
	______________________________
	Date of Birth (month/day/year)
______________________________	______________________________
Signature of Physician	Date

Forms/ECFMG Authorization Release
1/2007