COLLEGE OF MEDICINE
THE UNIVERSITY OF TOLEDO

College of Medicine
Graduate Medical Education

Document/Records Release Form
Authorization for Release of Education

I hereby authorize The University of Toledo to obtain my academic records, transcript, and any other documents maintained by any educational institution in which I was enrolled that reflect my professional qualifications, competence, ethics or character.

I understand that the purpose of this disclosure is for verification of my credentials.

I understand that I will not receive a copy of the records as disclosed, but may view the document(s) which will be maintained in the Graduate Medical Education office.

Printed Name of Physician	SS#
Signature of Physician	Date