

**AUTHORIZATION TO RELEASE MEDICAL RESIDENCY RECORDS**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.D. (“Physician”), hereby authorize Virginia Mason Medical Center (“Virginia Mason”) to release my medical residency program training records to the organization(s) identified below, for purposes of verifying my medical residency program training at Virginia Mason, including but not limited to dates of training, my standing in the program, and whether any disciplinary proceedings were undertaken against me. I release Virginia Mason, and its directors, officers, agents and employees, from any and all claims or liability arising from the release of such records.

Residency Program at Virginia Mason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year Graduated: \_\_\_\_\_\_\_\_\_\_\_\_

If applicable: maiden or previous name while training at Virginia Mason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and address of Organization(s) Requesting Records:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_