Authorization and Release of Information
GWU Residents/Fellows

I hereby authorize The George Washington University School of Medicine and Health Sciences (GWU), its Office of Graduate Medical Education (GME), its faculty, deans, program directors and administrative or other staff to provide verbal or written information regarding verification of my training at GWU, my professional competence, character and ethical qualifications to program directors, administrators and members of the staffs of other residency/fellowship programs, institutions, credentialing organizations, licensing agencies or any others whom I have authorized to receive such information. I further consent to the release of all documents, including GME files, program files, evaluations, or any other material requested by the above entities.

I hereby release from liability all representatives of GWU, including its GME Office, faculty, deans, program directors and administrative staff for all acts performed in good faith and without malice in connection with the release of any information provided pursuant to this authorization.
A photocopy of this form shall have the same effect as the original.

_____

Name (please print)

_____

Signature

_____

Date