THE UNIVERSTY OF CHICAGO PRITZKER SCHOOL OF MEDICINE
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CONSENT TO RELEASE INFORMATION

I, the undersigned, do hereby consent to the release of information and/or documents to the _____ by The University of Chicago and The University of Chicago Medical Center, their employees, faculty and staff that may be requested as part of an evaluation of my professional qualifications and competence to perform as a medical student, including information regarding my moral and ethical qualifications.

I release from all liability, including, but not limited for libel, slander, breach of privacy and confidentiality, The University of Chicago Medical Center, their employees, faculty and staff whom provide information pursuant to this consent.

_____

Name of Student/Physician (type or print)

_____ _____

Signature of Student/Physician Date