THE WARREN ALPERT Medical School
BROWN UNIVERSITY

The Warren Alpert Medical School
Brown University
Box G-M1
222 Richmond Street
Providence, RI 02912

Release Consent and Authorization

Section 1 – Student/ Alumni Information

Name:	
Date of Birth:	Phone Number:

Section 2 - Disclosure

I, the undersigned, authorize Brown University to ☐ release to

Name/Organization:	Mailing Address:
Phone (with area code):	Email Address:

The following information and/or records:

☐ Information regarding my:
- ☐ educational record
- ☐ verification of graduation

For the following purpose/proposed use:

☐ verification of my medical school studies/attendance/graduation

Section 3 – Method of Transmittal

Please use the following method of record transmittal:

☐ Mailed to the above address ☐ Emailed to the above address	

Section 4 – Consent and Authorization

I certify that this request has been made voluntarily and that the information given above is complete and accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time in writing, except to the extent that action has already been taken to comply with it. Without my express written revocation, this Authorization will automatically expire upon satisfaction of the need for disclosure, but in any event on the earlier of ([date]), or 180 days from the date below. A facsimile or photocopy of this Authorization shall be considered as effective and valid as the original. I hereby release Brown University, its employee and agents, from any liability to me or anyone claiming by, through, or under me, which may arise directly or indirectly out of the University's good faith compliance with this Authorization.

I have read this Consent and Authorization prior to signing and I understand its contents.

Signed: _____	Date:
Print Name:	