Authorization and Release

I authorize the release of any files or records required to process this application.

I hereby release NYU School of Medicine and NYU Langone Hospitals, its officers, employees, and representatives who provide information regarding my credentials.

Further, I agree to indemnify, defend and hold NYU School of Medicine and NYU Langone Hospitals harmless, from any and all liability for providing any information that may be relevant to an evaluation of my professional qualifications, including information about disciplinary actions or other credentials or confidential information.

By signing the below, I further acknowledge that I have read and understand the foregoing Authorization and Release and agree that a facsimile or photocopy of this Authorization and Release shall be as effective as the original.

Signature: _____

Print Name: _____

Date: _____

NYU School of Medicine
Office of Graduate Medical Education
545 First Avenue Room SC1-081, New York, NY 10016 tel 212.263.5506 fax 212.263.1014