AUTHORIZATION AND RELEASE

I hereby authorize SUNY Upstate Medical University ("Upstate"), including its individual employees, officers and agents, to verify to all sources and all information in any form from my graduate medical education file that Upstate deems relevant to my verification of postgraduate training. I understand and agree that such information may include, without limitation, information relating to my education and training, character and professional competence (including quality assurance and other privileged information). I hereby authorize Upstate, its employees or agents for this purpose to provide all such information to the verifying agent, and I acknowledge that Upstate, its officers and employees and all such other individuals, institutions and organizations may rely upon my authorization contained in this document and need seek no further authorization from me for this purpose.

I hereby release from all liability the State University of New York, Upstate and their employees, officers and agents, and such other individuals, institutions or organizations, and their respective heirs and assignees, for all acts performed and statements made in good faith and without malice in connection with the request.

Signature: _____
Name: _____
Date: _____