**RESIDENT/ALUMNUS AUTHORIZATION FOR RELEASE OF INFORMATION**

Resident/Alumnus name:

Residency program:

Inclusive dates of residency:

# Name of program director during residency:

I authorize Western Michigan University Homer Stryker M.D. School of Medicine (formerly MSU/KCMS and SMAHEC) to release information from my residency file, waiving any right I may have to written or oral notice of this disclosure or production of my information, to the to the organization/individual listed below.

I agree that I will not bring legal action against Western Michigan University Homer Stryker M.D. School of Medicine, its affiliated institutions, or any individual based on their responses to information requested by this organization/individual.

Documents requested to be completed:

Resident/Alumnus Signature

Typing my name above and submission of this form constitutes an electronic signature.

Date

Please release information to:

Organization/Individual Name:

Address: