



Authorization of Information Release

The AMA Physician Masterfile is a data source not only for internal use but also for use by other professional medical organizations, universities and medical schools, research institutions, governmental agencies, and other related groups. The use of Physician Masterfile data by agencies and organizations concerned with verifying physicians' credentials and health manpower planning is fundamental to the AMA's mission to strengthen the medical profession and ensure quality health care for the American public. Users of the Physician Masterfile may identify areas of a physician's record that require change or reverification. The AMA requires that changes submitted to a physician's medical school attendance or post graduate medical training be verified through the appropriate institution (primary source) before making changes to the the Masterfile.

In order to initiate verification of these credentials, most institutions require written permission before releasing details to outside parties. Therefore, we request your assistance in completing this form and signing in the space provided authorizing your consent to release details about your education and/or training to the American Medical Association.

To expedite the verification process we also ask that you please provide copies of your medical degree or training certificates. The completed *Release of Authorization* along with supporting documentation can be mailed or fax to the address below:

American Medical Association
Division of Survey and Data Resources
515 N State Street
Chicago, IL 60610
312 464-2587
312 464-4880 (fax)

For identification purposes, please complete all requested information below:

Legal Name (Printed): _____ Birth Date: ____/____/____

Mailing Address: _____

City: _____ State: _____ Zipcode: _____

Medical School: _____ Grad Year: _____

Contact Phone: _____

I hereby authorize the release of information pertaining to my medical school attendance and/or post graduate medical training to the American Medical Association.

Signature

Date