

University of Kentucky College of Medicine Authorization for Release of Educational Information

I hereby give my consent to the UKCOM Registrar to release information and copies of documents relating to my medical education at the University of Kentucky College of Medicine to:

Organization to receive information/documents

Address of organization

City

State

Zip

I understand that I am authorizing the release of information contained in my medical educational records which may include but may not be limited to dates of attendance, course registration, grades, evaluations, reports on professional conduct, academic honors, and copies of my educational records including but not limited to transcript (please see Transcript Request Form), diploma, Dean's Letter, Medical Student Performance Evaluation (MSPE), and USMLE Step 1 and Step 2 dates and scores.

Please send copies of the following to the organization indicated above:

Official Transcript

Unofficial Transcript

Certified Diploma (Please provide copy of diploma if you graduated prior to 1981.)

Dean's Letter/MSPE

Letter certifying your dates of attendance and award of MD degree

USMLE Step 1 and Step 2 dates and scores (We cannot provide Step 3 scores.)

Other:

Your name at the time of graduation

Your current name if different

SSN

Graduation Year

Mailing Address

City

State Zip

Phone

E-mail

Signature

Date

Please complete this form, print and sign it, and send it to UKCOM Registrar, 138 Leader Avenue, Lexington, KY 40506-9983, fax 859-323-2076.

NOTE: Per university regulation, no information or copies of educational documents will be provided for any alumnus who has an outstanding financial obligation to the University of Kentucky.