EINSTEIN
Albert Einstein College of Medicine

Office of Academic Appointments

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AUTHORIZATION TO RELEASE INFORMATION

It is the policy of the Albert Einstein College of Medicine to verify the highest degree for our newly appointed faculty and fellows. In order for us to verify your degree, we will need you to provide us with a release. Please read and sign below, authorizing us to obtain this verification.

I hereby authorize each of my former employers, as well as educational institutions, to release all information concerning my employment and education to the Office of Academic Appointments of Albert Einstein College of Medicine. I will hold each employer and educational institution harmless for the release of such information and I will also hold Albert Einstein College of Medicine and its related institutions harmless for requesting and utilizing such information.

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Social Security Number _____ Date of Birth _____

Signature _____ Date _____