Authorization for Release of Information, Documents and Records

I, the undersigned, hereby authorize _____ to collect the following information concerning my academic education and qualification at the Faculty of Medicine of the University of Cologne, Germany.

I authorize every department at the University of Cologne to release to _____ the following information and to submit medical school transcripts, certificates and other documents concerning my academic history at the Faculty of Medicine of the University of Cologne.

Date of enrollment: _____ until _____

Degree: 1) physician ☐ (state examination) 2) medical doctor (MD) ☐

Date of Degree: 1) _____ and/or 2) _____

Others: _____

Undersigned printed name	
Date of Birth	
Place of Birth	
E-mail	

Date: _____ **Signature:** _____

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