GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Health Professional Licensing Administration

AUTHORIZATION FOR RELEASE OF INFORMATION

To:

APPLICANT/LICENSE: ______________________________

I HEREBY AUTHORIZE YOU TO FURNISH THE BOARD OF MEDICINE / ADVISORY COMMITTEE ON PHYSICIAN ASSISTANTS OF THE DISTRICT OF COLUMBIA ALL RECORDS, REPORTS, ABSTRACT, EXCERPTS, AND OTHER DOCUMENTS AND/OR INFORMATION WHICH THE BOARD MAY REQUEST IN RELATION TO MY PROFESSIONAL CAPACITY.

A PHOTOCOPY OF THIS FORM SHALL HAVE THE SAME EFFECT AS THE ORIGINAL.

DATE: ________________ ____

Signature of Applicant/Licensee

Subscribed and sworn to before me by ____

this ____________________ day of 19______________ by the affiant, who personally appeared before me.

____

(Signature and seal of Notary)

My commission expires: _______________________________

Seal