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, 800 Rose St., MN-104, Lexington, KY 40536-0298, fax 859-323-4094, med.registrar@uky.edu.

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.*