UNIVERSITY OF IOWA
HEALTH CARE

Graduate Medical Education

200 Hawkins Drive; C-123 GH
Iowa City, IA 52242-1009
319-384-7620 ***Tel***
319-467-5559 ***Fax***
gmeoffice@uiowa.edu
https://gme.medicine.uiowa.edu/

Authorization/Release

I, ____, authorize the University of Iowa Hospitals and Clinics, Iowa City, Iowa, to release information related to my past and present professional liability insurance coverage, claims history, dates of residency and other training, confirmation of employment status, and release of my training file, which may include but not be limited to performance data, evaluations, remediation plans/results, discipline and my summative or other reviews and evaluations, to:

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I release from liability, and agree to indemnify and hold harmless all those furnishing information, for the acts or omissions performed in good faith and without malice in connection with the gathering and exchange of information as consented to above. A copy of this waiver shall be as effective as the original when so presented.

_______________________________________ ________________
(Legible Signature) (Date)

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(Date of birth)

(Return completed release to address, fax or email address noted above.)