



INFORMATION RELEASE FORM

Permission for Boston University School of Dental Medicine (BUSDM) to release information contained in a student's record.

I, _____ ,
[print name]

hereby grant permission to BUSDM or its designated administrative officer to release information contained in my academic record as a student or a postgraduate at BUSDM to those persons or places requested by **in writing** for the purpose of letters of recommendation for clerkships, scholarships, externships, research programs, fellowships, outside electives, residency training programs, hospital, and staff privileges.

[signature]

[date]