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To Whom It May Concern:

I,______________________________, MD/DO, authorize the Graduate Medical Education office to release information concerning any malpractice claims filed against me during my residency/fellowship in _______________________, from____________to_____________.

Please forward this information to the attention of:

Name of Institution:______________________________

Contact Name:__________________________________

Address:______________________________________

Phone/Fax:____________________________________

Email Address: _________________________________

Signature:_____________________________________Date: __________________________

Please return form to:
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