UPMCME AUTHORIZATION AND RELEASE

I hereby authorize UPMC Medical Education ("UPMCME") and its UPMC system affiliates, including respective individual employees, officers, representatives and agents, to verify to all sources and all information in any form from my UPMC graduate medical education file that UPMCME deems relevant to my verification of my UPMC postgraduate training. I understand and agree that such information may include, without limitation, information relating to my education and training, character and professional competence (including quality assurance and other privileged information). I hereby authorize UPMCME, its employees or agents for this purpose to provide all such information to the verifying agent, and I acknowledge that UPMCME, its officers and employees and all such other individuals, institutions and organizations may rely upon my authorization contained in this document and need seek no further authorization from me for this purpose. I further understand and acknowledge that all such disclosures made in good faith shall be subject to immunity provisions of federal, state and local laws (including without limitation the Health Care Quality Improvement Act).

I hereby release from all liability UPMCME and their employees, officers and agents, and such other individuals, institutions or organizations, and their respective heirs and assignees, for all acts performed and statements made in good faith and without malice in connection with the request.

Signature: _____

Name: _____

Date: _____