**Consent and Authorization of Release of Information**

By Submitting this Authorization and Release of Information form in conjunction with my verification request, **I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize** and agree that once my fee is paid, representatives of The Johns Hopkins Hospital/Johns Hopkins University/Johns Hopkins Bayview will be providing information regarding my residency in their program to the following persons/institutions. I also understand that if a refund is needed, requests must be received within five (5) days of the program receiving my form. Refunds will not be granted once the request has been completed and sent out via trackable USPS, email or fax.

**Print Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_