Baystate Medical Center

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www.baystatehealth.org

AUTHORIZATION AND RELEASE

I hereby authorize Baystate Medical Center, Inc. ("BMC"), its employees, agents, medical staff members, and representatives (collectively, "BMC"), to release information, to the extent permitted by relevant law, concerning my participation in graduate medical education at BMC, as stated below. I hereby hold harmless and release BMC from any and all liability and from claims of any nature that might arise from BMC's furnishing such information pursuant to this Authorization and Release.

I agree that this Authorization and Release shall remain in effect from the date of signature specified below unless and until specifically revoked by me in writing, and further, that BMC may rely on this Authorization and Release unless and until BMC receives such written revocation. I agree that a photocopy of this Authorization and Release shall have the same effect as an original.

Name of Physician **Date of Birth**

Graduate Medical Education Program **Dates of Training**

I hereby authorize BMC to disclose information concerning my participation in the residency program referenced above to:

Addressee **Institution**

Street **City** **State** **ZIP**

Email **Telephone** **Fax**

Signature of Physician **Date**

PRIVILEGED AND CONFIDENTIAL
VERIFICATION OF TRAINING