UNIVERSITY OF CENTRAL FLORIDA
College *of* Medicine

GENERAL CONSENT RELEASE FORM

The UCF College of Medicine M.D. Program has generated significant interest from the community, locally and nationally. From time to time UCF College of Medicine is requested to give basic information about students.

I, _____ give permission for UCF College of Medicine

(Print Full Legal Name)

to release the following information:

1. Name
2. Photograph
3. Degree Granting Institutions
4. Degrees Conferred
5. AMCAS Activities/Personal Statement Information Excerpts (Volunteering, Research, etc.)
6. Place of Birth

I understand that the information may be released orally or in written form, as preferred by the requestor. I understand I may revoke this Consent prospectively.

_____

Print Full Legal Name

_____ _____

Signature **Date**