CONSENT TO RELEASE OF INFORMATION AND RELEASE OF LIABILITY IN RESPECT OF PM&DC AND THE INSTITUTION (Foreign Qualifications)

1. Name of Authorizing Physician and Email Address:_____

2. Identity of Institution or Person from whom information: is sought_____

3.***Said Qualification*** Name of Qualification(about which information is being sought) _____

Specialty:_____ Subspecialty:_____

4. (***Provider)institution awarding the degree***_____ with its relevant hierarchy, staff and Faculty who I am authorizing to release information concerning me and my qualifications.

5. ***Requester*** Identity of Institution or Person requesting information: "Pakistan Medical and Dental Council (PM&DC) or agents and authorized representatives/officials so designated in writing by or for it

PURPOSE: I am providing this request and consent in order to facilitate the process and verification of my qualifications from the above institution (provider) by the PM&DC (requester).

REQUEST*:* I specifically request that (provider)_____ provide to the requester or any representative designated in writing by the requester, any and all information, documents, and records concerning" my professional performance; competence, character during attainment of qualifications including syllabus etc, registration of the qualification information work experience and behavior while a resident and/or fellow, specifically including the circumstances of my departure from the institution. I further specifically request that (provider) _____provide such information whether it came into possession of that information prior to my residency/fellowship, during my residency/fellowship, or after my residency/fellowship towards attainment of the said Qualification.

CONSENT AND AUTHORIZATION: I hereby authorize the requester identified above, or any representative designated in writing by that requester, to consult with(provider)_____its relevant hierarchy, staff and Faculty, in order to obtain any and all information, documents, syllabi, teaching methodology and records concerning" my professional performance; competence, character, qualifications, work/teaching experience and behavior while a resident and/or fellow, specifically including the circumstances of my departure from the institution. I hereby consent to the release of any and all information, records, documents, and/or opinions that PM&DC may require in their sole discretion and this may be provided to the PM&DC(requestor) pursuant to this authorization. I further consent to the copying of documents by(provider) _____its relevant hierarchy, staff and Faculty, and transmittal to the requester or its representatives, of any and all records syllabus and teaching methodology, documents, and/or opinions described in the paragraphs above, as well as any other information, documents and/or opinions that may be material to an evaluation of my professional qualifications in order for PM&DC to consider it for registration and my competence to practice medicine, my qualifications to obtain or hold clinical privileges or professional credentials, and my moral and ethical qualifications for employment. I hereby consent to the consultation and to the provision of information, records, documents, and/or opinions described above to the requester now, or at any time in the future, in the event of a subsequent inquiry or request. I further consent to a supplemental consultation and to the provision of supplemental information, syllabus and teaching methodology records, documents, and/or opinions at any time in the future in the event that the (requestor) _____its relevant hierarchy, staff and Faculty, in their sole discretion, determines for any reason that information or opinions it has previously provided pursuant to this release are no longer complete, accurate, or timely, or that such information should be amended to make it more complete, accurate, or timely.

WAIVER OF LIABILITY: I hereby release the requester, _____its relevant hierarchy, staff and Faculty, and their respective representatives from all liability, to the fullest extent permitted by the law, for any and all acts performed under this authorization, specifically including the provision of information, documents, or records pursuant to this request.

RELEASE AND WAIVER OF ALL CLAIMS: I specifically waive any claim for damages of any kind against (provider) _____its relevant hierarchy, staff and Faculty, for acts performed pursuant to this authorization, to the fullest extent permitted by the law, including but not limited to claims of interference with contract, invasion of privacy, defamation, slander, discrimination, denial of employment, admission, licensure, or credentials, or negligence of any kind in the communication of such information to the requester or its representatives.

HOLD HARMLESS AND INDEMNIFICATION: I hereby agree to hold (Provider)_____its relevant hierarchy, staff and Faculty, and their representatives harmless from any and all claims made against them by me, the requester, or any other person or entity as a result of the release of information, documents, or records pursuant to this authorization. Specifically included in "hold harmless and indemnification" within this paragraph are any claims arising from denial of employment, admission, or credentials to me-by the requester or its representatives. I further specifically agree to indemnify (Provider) _____ its relevant hierarchy, staff and Faculty and their Representatives for any and all legal fees, costs, or any other expenses incurred in defending any claim arising from the release of information, records, or documents sought by this request or provided pursuant to this authorization.

I shall pay fee for this verification to the provider if any

Signature of Authorizing Physician _____ Date _____

Print Name of Authorizing Physician _____