AUTHORIZATION TO RELEASE INFORMATION

I, [Full Legal Name of Applicant], authorize any licensing board, medical school, employer, hospital, credentialing body, or records custodian to release information related to my professional licensure, education, training, employment, credentials, and application status to the consulting service listed below for the purpose of assisting with my medical licensure process.

Authorized Recipient:
ADG Experienced Licensing Services
Wendy Alls, Angela Denson, Karell Goldwire
1632 Metropolitan Blvd, Suite A
Tallahassee, FL 32308

Information that may be released includes licensure status, deficiency notices, examination verification, education and training verification, employment verification, credentialing records, correspondence regarding my licensure application, and other relevant documents.

This authorization allows the consulting service to communicate with the above entities regarding my licensure file. It does not grant permission for legal representation.

This authorization remains valid until: [Expiration Date or “Completion of Licensure Process”]

I understand this authorization is voluntary and may be revoked in writing at any time.
A photocopy or electronic copy of this authorization shall be considered valid.

Applicant Name: ______________________________________

Date of Birth: ______________________________________

License Type / Profession: ______________________________________

Application/File Number: ______________________________________

Phone: ______________________________________

Email: ______________________________________

Applicant Signature: ______________________________________

Date: ______________________________________