



UConn Health Office of the Registrar
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Office: Academic Building, AM039

Release Form: Medical and Dental Students

Student's Name (Last, First, MI): _____

Other name(s) used during attendance: _____

Date of Birth: ____/____/____ **School** (Medical or Dental): _____

Dates of Attendance: From: _____ To: _____

Please provide preferred contact information where you may be reached:

Phone: _____ Email: _____

I hereby authorize the University of Connecticut to release my information and related documents to the recipient(s) named on this form.

Date: ____/____/____ **Signature:** _____

(Handwritten signature required; we cannot accept a digital or typed signature)
