



## Affidavit and Authorization for Release of Information Request

I, the undersigned, hereby certify under oath that I am the person named below, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named on this form and credentials furnished or to be furnished with respect to my request and that all documents, forms or copies thereof furnished or to be furnished with respect to my request are strictly true in every aspect.

I hereby release, discharge and exonerate the Federation of State Medical Boards, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind.

I authorize the Federation of State Medical Boards to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

Physician's Printed Name: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date of Signature: \_\_\_\_\_

Physician's Telephone Number or Email Address: \_\_\_\_\_

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### Submit form

By email to: [closedprograms@fsmb.org](mailto:closedprograms@fsmb.org)

By fax to: 817-868-4150