University of Iowa College of Pharmacy

AUTHORIZATION TO RELEASE INFORMATION OR REQUEST FOR LETTERS OF RECOMMENDATION

TO:   
(Name of University Official and Department)

Please:
   ___ Write a letter of recommendation
   ___ Complete evaluation form
   ___ Release information verbally
   ___ Other (please specify)__________________________

To:
   ___ All potential employers
   ___ Any educational institution
   ___ Only to (please specify)__________________________

For the following purpose:
   ___ Employment
   ___ Admission to an educational institution
   ___ Other (please specify)__________________________

I authorize you to consult my educational record at the University of Iowa to reveal such information from my educational record, as you consider appropriate for the purpose(s) stated above.

I waive/do not waive (circle one) my right to see the recommendation or other information prepared pursuant to this release.

Print Name ___________________________________________________________________

Signature ___________________________________________________________________

Student ID ___________________________________________________________________

Date _______________________________________________________________________