Duke Visa Services

University - Medical Center - Health System - Affiliated Institutions

AUTHORIZATION TO RELEASE INFORMATION

Release of information to third parties, such as to immigration lawyers, requires your permission. If you wish for us to work with or release information to an immigration attorney, or to release information to any other third party, you need to complete this release document and either sign it in the presence of a representative of Duke Visa Services or have your signature notarized by a U.S. notary public.

I, (print name of person releasing information) _____

born (month/day/year of birth) _____ in (country) _____,
authorize Duke University, Medical Center, and Health System
to release information pertaining to my or my dependents' visa status, immigration status, or work authorization status in the U.S.
to (name, and contact information for attorney or other person being authorized to receive information)

Name: _____

Street or mailing address: _____

City: _____ State: _____ Zip code: _____

Telephone: _____ Facsimile: _____

E-mail: _____

Notes or restrictions, if any.

_____

_____

Releaser Signature: _____ Date: _____

Witness signature: _____ Date: _____

Name of witness typed or printed: _____