MUSC RESIDENCY VERIFICATION RELEASE FORM

Date:

To Whom It May Concern:

I, the undersigned, hereby authorize The Medical University of South Carolina [MUSC] to verify my residency information as required for:

☐ Licensure ☐ Employment ☐ Credentialing ☐ Other: _____

I hereby give my consent to release the following information:

- **Full Name:** [Insert Full Name]
- **Date of Birth:** [Insert Date of Birth]
- **Current Address:** [Insert Address]
- **Previous Address (if applicable):** [Insert Previous Address]
- **Dates of Residency:** [Insert Dates]
- **Phone Number (optional):** [Insert Phone Number]

I understand that this verification process may involve contacting the relevant local authorities, housing providers, or other sources of my residency information.

By signing below, I authorize the release of my residency verification for the purpose stated above and acknowledge that this consent is provided voluntarily and without coercion. I further understand that I may revoke this consent at any time by providing written notice to the organization or agency to whom this form was submitted.

Signature of Applicant: _____

Printed Name of Applicant: _____

Signature of Authorized Representative (if applicable): _____

Date: _____