



*Release of Information Form*

I, \_\_\_\_\_, the undersigned, hereby authorize my educational institution (Records Custodian), to release and provide to:

Name: **Embassy of the State of Qatar** (Medical Office )

Address: **2555 M St. NW Washington DC 20037**

Fax: (202)237-8393 or E-mail I to [qatarmd@gmail.com](mailto:qatarmd@gmail.com) with copies of documents as may be listed below. I acknowledge that I understand the purpose of the request and that authorization is hereby granted voluntarily.

Student Information:

**Ref number:**

Student Name (Last, First, Middle):

Address:

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Date of Birth (mm/dd/yy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Requested Information or Documents:

**Student enrollment status**

Other (Please explain in detail):

Dated this \_\_\_\_\_ day of \_\_\_\_\_,

**By my signature below, I consent to the release of the above listed information / documents.**

Printed Name of Student: \_\_\_\_\_

Signature of Student: \_\_\_\_\_