



Upholding Excellence in Medical Education

CONSENT FORM

I (PRINT NAME) do authorize and give my consent to disclose my name, other necessary personal information, my written complaint/correspondence and corroborating materials to the Dean of (INSERT SCHOOL NAME) and where necessary to members of staff of (INSERT SCHOOL NAME), and of ACCM, their respective attorneys and any other appropriate outside third parties. ACCM will only release such information as is necessary to enable the investigation of a complaint made.

Signed:

Dated:

Please select from the list your Current Relationship to the School named above:

If you selected *Previous Student* or *Other* please specify: