



AUTHORIZATION FOR INVESTIGATION AND RELEASE OF INFORMATION

I, _____, hereby authorize the administration of the **Charlotte County Medical Society**, or authorized Medical Staff representative on behalf of the Charlotte County Medical Society to obtain information necessary to process my application for membership to the Society. I authorize the Charlotte County Medical Society to contact any references listed by me on my application for membership in the Society. I agree to hold them and any person or organization answering their inquiries about my qualifications, education, experience, character, and citizenship harmless from any claims by me for any statements which they may make concerning me.

I agree that a copy of this release shall be sent to those references listed in my application for membership, together with a request for information concerning me and my background, in order that the people writing reference may be free to express their honest opinions about my abilities as a physician and my reputation as a citizen to the officers and officials of the Charlotte County Medical Society, who are considering my application for membership.

DATE

SIGNATURE OF APPLICANT