

# 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: \_\_\_\_\_