AFFIDAVIT AND RELEASE OF INFORMATION

I, _____, certify after being duly sworn, that all of the information supplied in the Mississippi State Board of Medical Licensure's online application is true and correct to the best of my knowledge, that the photograph submitted herein is a true likeness of myself and was taken within sixty (60) days prior to the date of this release. I acknowledge that any false or untrue statement or representation made in the online application may result in the denial of initial licensure or the revocation of any license to practice medicine granted to me.

I further authorize the release of the online application and any information submitted with it or information collected by the Mississippi State Board of Medical Licensure in connection with the online application, including derogatory information, to any person or organization having a legitimate need for the information and release the Mississippi State Board of Medical Licensure from all liability for the release of this information.

I further authorize the release of information, including derogatory information, which may be in the possession of other individuals or organizations to the Mississippi State Board of Medical Licensure and release this person or organization from any liability for the release of information.

I further authorize each educational institution at which I have applied for any license, permit, certificate or registration; each person, firm, corporation, clinic, office, or institution by whom or with whom I have been employed in the practice of medicine; any hospital at which I have or have had membership; each insurance company with which I have obtained or made application for medical malpractice liability insurance; and each professional organization or specialty board to which I have applied for m embership, to disclose and release to the Mississippi State Board of Medical Licensure, 1867 Crane Ridge Drive, Suite 200-B, Jackson, MS
39216, any and all information and documentation concerning me which the Board deems material for consideration of my application. Further, I hereby consent to the disclosure and release of such information and documentation to the Mississippi State Board of Medical Licensure and waive any privilege or right of confidentiality which I would otherwise possess with respect thereto.

I further authorize any person, firm, corporation, clinic, office, institution, state or federal agency from whom the Mississippi State Board of Medical Licensure has requested information to rely on a copy of this release, the original now on file in the office of the Mississippi State Board of Medical Licensure at the above noted address.

I also agree to execute any other release or authorization, the execution of which may be required under federal or state law prior to release of any of the documents or information requested.

Date _____

_____
Applicant's Signature

County of _____

State of _____

SWORN to and subscribed before me this _____ day of _____, in the year of _____.

_____
Notary Public

My Commission Expires: _____

(SEAL)

Attach a Passport-Type

Photograph

Taken Within 60 Days.

Informal Snapshots Will Not Be Accepted.

Complete and Submit to:
Mississippi State Board of Medical Licensure
1867 Crane Ridge Drive, Suite 200-B
Jackson, MS 39216

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