AUTHORISATION FOR RELEASE OF INFORMATION AND DOCUMENTS

I, the undersigned, hereby authorize Medical University of Varna to collect, verify and maintain information from the University/ies I have attended.

I hereby agree an official verification request to be sent by MU-Varna to the ……..

……,

concerning my periods of study, major, grades and obtained degree/s as I agree with the releasing of personal information, transcripts and other documents concerning my status with and by my previous educational institution/(s).

A photocopy of this authorization shall be as valid as the original and shall be valid from the date signed by me.

I further agree the information requested by Medical University of Varna to be directly submitted to:

Medical University "Prof. Dr. Paraskev Stoyanov"

Office of Admissions

55, Marin Drinov Str.

9002 Varna, Bulgaria

Name: ……

Address:……..

Date…… **Signature ……**