



UNIVERSITY
SCHOOL OF PUBLIC HEALTH

Release Form

I hereby authorize Drexel University College of Medicine to release my medical school admission file to the School of Public Health. *Please print clearly.*

Name: _____
Last First MI

Address: _____
Street

_____ City State Zip

Telephone: () _____

Email Address: _____

I am applying to the full-time Master of Public Health program.

Signature: _____

Please send this completed and signed form to **Helene LaBenz:**

Fax: (215) 762-8846

or

Mail: Mail Stop 660, 245 N. 15th Street, Philadelphia, PA 19102

Upon our receipt of this form, you will be sent a confirmation email.