



**California State Board of Pharmacy**  
2720 Gateway Oaks Drive, Suite 100  
Sacramento, CA 95833  
Phone: (916) 518-3100 Fax: (916) 574-8618  
www.pharmacy.ca.gov

Business, Consumer Services and Housing Agency  
Department of Consumer Affairs  
Gavin Newsom, Governor



## **AUTHORIZATION TO RELEASE APPLICANT INFORMATION** (Optional)

**Applicant Business Information – Please print or type**

**FILE #**

\_\_\_\_\_  
Name of Business Telephone Number of Business

\_\_\_\_\_  
Name of Business DBA if different than above

\_\_\_\_\_  
Address of Business – Street City State Zip Code

The board will ONLY discuss the status of this application with the authorized person identified on the application and any person who has signed the application as an officer, partner, member, and/or owner of the applicant business. In order for the board to discuss the status of this application with another individual, the authorized person identified on the application must authorize in writing the board to discuss the application status with a his or her authorized representative.

Giving consent for the board to disclose application and business information will authorize the board to disclose all personal and business information pertaining to this application. This includes but is not limited to social security number, date of birth, address information, all application requirement information, application approval or denial status, and any criminal conviction information the board may have on record for your application.

**Applicant Consent – Must be signed and dated by the applicant for optional authorization to be valid.**

As a person identified on the application that is authorized to act for and bind the applicant business, I hereby give the board consent to communicate to the individual listed below.

I, \_\_\_\_\_, hereby give consent to  
Print Name of Person Authorized to Bind the Applicant Business

the California State Board of Pharmacy to disclose information about this application as specified above to the following individual:

\_\_\_\_\_  
Name Telephone Number Email Address

\_\_\_\_\_  
Mailing Address – Street City State Zip Code

This consent will expire on \_\_\_\_\_, within one year, or upon  
licensure, whichever comes first. (Date)

\_\_\_\_\_  
Original Signature of Person Authorized to Bind the Applicant Business Date