Authorization for Disclosure of GED® Documents and Information

Please complete this form as accurately as possible. By signing, you consent to the release of your GED records. Please allow 7 - 10 business days to complete once received.

Social Security Number	
Date of Birth	
Last Name	
First Name	
Middle Name/Initial	
Full Name at Time of Testing	
Current Address (Line 1)	
Current Address (Line 2) or Apt. #	
City, State, Zip code	
Home Phone (*including area code*)	
Cell Phone (*including area code*)	
Fax Number	
Email Address	
Approximate Date(s) Tested in Virginia	

Send to:	**Location**
Full Name of Recipient	
Address (Line 1)	
Address (Line 2)	
City	
State	
Zip code	
Phone Number (*including area code*)	

In requesting and authorizing disclosure of these documents, information, and/or records, I hereby agree to the following:

1. I understand and acknowledge the GED Testing Program's right to make an independent determination, at its sole discretion, of whether the information and records identified above are subject to disclosure under the GED Testing Program's policies for disclosing information to third parties.
2. I hereby release the GED Testing Program, its employees, its attorneys, its governing bodies, and its agents from any and all liability and claims of every kind and character that are based upon or relate in any way to the disclosure of information in accordance with this authorization of any actions of the third party identified above.
3. I agree that this authorization is valid until such time as the GED Testing Program has received written notice from me (or from me and my parent or guardian, if I am a minor) withdrawing permission to disclose the documents or information specified above to the third party identified above. In the event that permission is withdrawn, the GED Testing Program shall nevertheless remain fully protected from any and all claims and liability relating in any way to information released by the GED Testing Program prior to its receipt of the written withdrawal notice and to any actions of the third party.
4. I understand that, subject to its independent determination, the GED Testing Program will disclose the designated material that it has at the time it receives my request. I also understand that in the absence of an additional request from me, the GED Testing Program will not provide information that becomes available at a later date.

I have read this authorization carefully and hereby acknowledge that I fully understand it. I further affirm that I am giving this authorization knowingly of my own free will.

Signature of Candidate: _____ Date: _____/_____/_____

Signature of Candidate's Parent or Guardian: _____ Date: _____/_____/_____
(if candidate is under 18 years of age)
Printed Name of Parent or Guardian: _____

Please mail to: Mount Rogers Regional Adult Education Program
P.O. Box 828
Abingdon, VA 24212

Or fax to: 276-739-2572

Revised: 12/3/12