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| **AUTHORIZATION FOR THE RELEASE OF INFORMATION** |
| **CHIPOLA COLLEGE TESTING CENTER****3094 INDIAN CIRCLE****MARIANNA, FL 32446**[**www.chipola.edu**](http://www.chipola.edu)**Phone: 850.718.2284** |
| **STUDENT INFORMATION** |
| **First Name** |  |
| **Last Name** |  |
| **Social Security Number (Last four digits)** | **xxx-xx-\_\_\_ \_\_\_ \_\_\_ \_\_\_** |
| **Date of Birth** |  |
| **I willingly and knowingly authorize the above Chipola College to send the information requested.****Student Signature: Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **INSTITUTION INFORMATION** |
| **I authorize Chipola College to release information to the following institution by way of:** |
|  **Check one:** | **\_\_\_\_\_\_Email \_\_\_\_\_\_Postal Service** |
| **Name of Institution** |  |
| **Street Address** |  |
| **City, State & Zip Code**  |  |
| **Name of Contact Person** |  |
| **Phone Number** |  |
| **Email Address** |  |
| **Type of Test** |  |
| **Date of Testing (month & year)** |  |

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| **Email to:****testingcenter@chipola.edu** |



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