

**Authorization and Release Form**

I, \_\_\_\_\_, in connection with my application for testing accommodations, authorize the American Board of Criminalistics (the Board) to provide at its discretion, a copy of any and all documentation I submit in conjunction with this application, including confidential medical records or information, to a licensed unbiased medical professional the Board may deem necessary to adequately evaluate my application for testing accommodations.

If further information regarding the submitted documentation I provided is necessary, I authorize the Board to contact the licensed medical professional(s) who diagnosed / treated my disability. I also authorize said licensed medical professional(s) to communicate with the Board in this regard to provide clarification and / or additional information and documentation as the Board requires.

I authorize the Board to contact any entities which have provided testing accommodations for me in the past to ascertain what accommodations were granted or denied. I further authorize these entities to communicate with the Board in this regard to provide clarification and / or further information and documentation as the Board requires.

I hereby release, discharge and exonerate the American Board of Criminalistics, its representatives, employees and members from any and all liabilities of every nature that may arise out of furnishing, inspection or receipt of medical records, documents, other information or any investigation made by or on behalf of the Board.

Printed name of applicant: \_\_\_\_\_

Signed name of applicant: \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_,  
20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public  
(Official seal or stamp must be affixed.)