

AUTHORIZATION TO RELEASE OFFICIAL GED DOCUMENTS

PLEASE TYPE OR PRINT THE FOLLOWING INFORMATION. IF YOUR APPLICATION IS INCOMPLETE, RECORDS OF YOUR TESTING WILL NOT BE PROVIDED. COMPLETED REQUEST SHOULD BE MAILED OR FAXED TO:

Arkansas GED Testing
#3 Capitol Mall, Room 305D
Luther S. Hardin Building
Little Rock, AR 72201
FAX 501-682-1982

PART I: AUTHORIZATION TO RELEASE GED DOCUMENTS DIRECTLY TO THE EXAMINEE PLEASE INDICATE THE REQUIRED DOCUMENTS BELOW.

Transcript

Diploma

Retest Application

NAME: _____
(At the time of testing) Last Maiden/Other First M.I.

YEAR TESTED: _____ WHERE: _____
(or approximate year)

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

CURRENT NAME & CURRENT
MAILING ADDRESS: _____

DAYTIME PHONE
NUMBER: _____

(Signature of Examinee)

(Date)

PART II: THIRD PARTY RELEASE

PLEASE CONTINUE IF YOU ARE REQUESTING THAT DOCUMENTS, INFORMATION, AND/OR RECORDS BE DISCLOSED TO A THIRD PARTY.

I hereby authorize Arkansas GED Testing to provide copies of the indicated documents to the following Third Party:

Transcript

Diploma

Retest Application

Third Party Name: _____

At the following address: _____

I understand and acknowledge the GED 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 Program's policies for disclosing information to third parties. I hereby release the GED 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 to any actions of the third party identified above.

(Signature of Examinee)

(Date)