AAMC
PREview® Professional Readiness Exam

Authorization to Release Health Information Pertaining to AAMC PREview® Exam Accommodations

This form authorizes the release of information pertaining to a request for special accommodations on the AAMC PREview exam. For the protection of your private information, the Office of Accommodated Testing Services will not release information to third parties regarding your accommodation request or the materials supporting your request, unless specifically authorized to do so through this release form. By completing this authorization, you are releasing the Association of American Medical Colleges (AAMC) from any liability resulting from the disclosure of information regarding your accommodations request to the below-designated parties or from the use of AAMC PREview information by the third parties. This release does not in any way obligate AAMC to provide information to the designated parties.

I understand that this authorization is voluntary. I understand that I have the right to revoke this authorization at any time, except to the extent that action has already been taken based on this authorization. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Office of Accommodated Testing Services as well as to the third parties named below.

Unless otherwise revoked, this authorization will expire in 12 months. I,_____, hereby voluntarily provide consent to the Director of Accommodated Testing Services and his/her designated Accommodated Testing Services staff or representatives, and the following named individuals, to share, at their discretion, information relating to my request for AAMC PREview accommodations including my personal medical and health information:

3d Party Contact Information

Full Name: _____

Organization: _____

Relationship: _____

Address: _____

_____

_____

Phone number: _____

Fax number: _____

Signature: _____

Date: _____