CERTIFICATION AND LICENSURE RELEASE OF INFORMATION FORM

Verification of Certification and Examination Scores Mailed to a Third Party

Name and Address of Third Party:____

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TYPE or **PRINT** the following information and mail this form to the address shown below.

Certifying Agency Name: American Society for Clinical Pathology
33 West Monroe Street
Suite 1600
Chicago, IL 60603

I am authorizing the certifying agency listed above to release my examination scores, **pass or fail**, and certification number for licensure purposes.

Name:____
(Last) (First) (M.I.)

Signature:____

Social Security Number:__________________________

Certification Category:__________________________

This form must be returned before the date of your examination.

Please mail this authorization form to:

Board of Certification
33 West Monroe, Suite 1600
Chicago, IL 60603

Revised 1/10