



STUDENT TESTING RELEASE FORM

Please complete and sign this form to have Accuplacer Test Scores released to you or to a College or University Testing Facility only.

AUTHORIZATION TO RELEASE RECORDS:

Student Name: _____
Student ID: _____
Student Address: _____
City: _____ State: _____ Zip: _____
Student Phone: _____
Email address: _____

I understand that my student educational records are confidential and the ACM Testing Lab cannot release my Accuplacer Test Scores without my written permission.

I authorize the ACM Testing Lab to release my Accuplacer Test Scores to:

Name: _____
College or University (if applicable): _____
Address: _____
City: _____ State: _____ Zip: _____
College or University Fax number: _____

My signature below indicates that I authorize the ACM Testing Lab to release my Accuplacer Test Scores, and that I have the right to revoke this authorization at any time by notifying the Testing Lab in writing that I wish for it to be cancelled.

Student's Signature _____ Date _____

- You may complete this form and turn it in to the ACM Testing Lab and present a valid picture ID at time of drop off.
- You may scan and email a copy to testing@allegany.edu or fax to 301-784-5060 along with a legible copy of your valid picture ID.