ACT Authorization to Release Personal Information

If you are eighteen years old and want us to speak with your parent, guardian, or others, you will need to complete and return the authorization form set forth below. If you are under the age of 18, we will speak to a parent or legal guardian, but that person must also sign this form to grant us permission to speak with anyone else.

I, _____, reside at the following address:

_____

My date of birth is _____, and I consent to the release of any and all records in the possession of ACT, Inc. ("ACT") which are in any way related to me.

ACT is authorized to release and make full disclosure of such records to, and to discuss any information relating to those records with, the following institution:

Barnes-Jewish Hospital, Express Scripts, Inc., on the campus of St. Louis College of Pharmacy (BESt) Pharmacy Summer Institute, Application Committee, PO Box 32810, Olivette, MO 63132

This authorization is effective immediately and will remain in effect until revoked by me in writing.

I hereby release and hold harmless ACT and its agents from any and all claims and actions based upon, arising out of, or relating in any way to any disclosure of records or information pursuant to this Authorization to Release Personal Information.

A copy of this document shall serve as the original.

Examinee Signature: _____ **Date**: _____

If the above-named examinee is under the age of 18, the parent or legal guardian of the examinee must also sign below indicating consent and agreement to this Authorization to Release Personal Information.

Parent or Legal Guardian Signature: _____ **Date**: _____

Please complete and send to:

ACT Test Security (53)
P.O. Box 168
Iowa City, Iowa 52243-0168
Phone: 319/337-1371
Fax: 319/341-2303