

AUTHORIZATION FOR THE RELEASE OF INFORMATION	
<p align="center">CHIPOLA COLLEGE TESTING CENTER 3094 INDIAN CIRCLE MARIANNA, FL 32446 www.chipola.edu Phone: 850.718.2284</p>	
STUDENT INFORMATION	
First Name	
Last Name	
Chipola ID #	
Date of Birth	
Phone Number	
Email Address	
I willingly and knowingly authorize the above Chipola College to send the information requested. Student Signature: _____ Date: _____	
INSTITUTION INFORMATION	
I authorize Chipola College to release information to the following institution by way of:	
Check <u>ONE</u> :	_____ Email _____ Postal Service
Name of Institution	
Street Address	
City, State & Zip Code	
Name of Contact Person	
Phone Number	
Email Address	
Type of Test	
Date of Testing (month & year)	
Email to: testingcenter@chipola.edu	



Chipola College is an Equal Access/Equal Opportunity Institution

<https://www.chipola.edu/equal/>

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