



AUTHORIZATION TO RELEASE INFORMATION

NOTICE: By signing below: (1) you will allow ICD to disclose confidential, personal, private information about you and your file at ICD to the person designated below; (2) you will give up the right to receive information from ICD; and (3) you release and indemnify ICD, its members, trustees, officers and employees from any liability for losses, damages or claims of any type arising out of actions taken by ICD in reliance upon this Authorization.

This authorization will remain valid for two years from the date written below (or if none, from the date this authorization is received by ICD).

REVOCATION: This authorization can be revoked by submitting a new authorization dated and signed after the initial Authorization.

In addition, you may revoke this authorization in writing at any time, which will be effective on and after the 30th day after ICD receives your written revocation by regular mail or courier at its headquarters office in Philadelphia, PA USA.

AUTHORIZATION: I authorize ICD to release to the below-named Authorized Recipient any and all information about me and my application/order for services from ICD, including without limitation, the status of my application/order, the results of any credentials review, examination or test, and any other information in or relating to my file at ICD. **I understand that all mail will be sent to the Authorized Agent.**

This authorization revokes all previous authorizations submitted by the applicant.

ICD ID No. _____ (if known)

Date of Birth: _____ (M/D/YR)

Sign name as it appears
on your Application/Order: _____

Print name: _____

Date: _____ (M/D/YR)

AUTHORIZED AGENT:

Print contact name: _____

Print organization name: _____

Print address: _____

Telephone: Day: _____ Fax number: _____

Evening: _____ E-mail: _____