FOREIGN CREDENTIALING COMMISSION ON PHYSICAL THERAPY

AUTHORIZATION TO RELEASE INFORMATION

Due to federal confidentiality laws, FCCPT is not permitted to release information to any third party without permission. This includes family members.

This authorization form will allow FCCPT to share information about your service(s) with a third party ("Authorized Representative"). Final Reports and Certificates will NOT be sent to an Authorized Representative.

I, _____, grant permission for FCCPT to release
Applicant's Printed Name

to the Authorized Representative named below, any information about my application for services from FCCPT, including the status of my service(s), the process towards any credentials review, examination or test, and any other information in, or relating to, my file at FCCPT.

SIGNATURE OF APPLICANT: _____

APPLICANT'S DATE OF BIRTH: _____
(MM/DD/YYYY)

FCCPT FILE NUMBER: _____

AUTHORIZED REPRESENTATIVE

Name of Representative: _____
(Name of an Individual, not agency)

Representative's E-Mail Address: _____

Expiration of Authorization

If applicable, please specify a date for which authorization shall expire. ***If no expiration date is provided, this authorization will remain valid until revoked in writing. You may revoke this authorization at any time prior to the specified expiration by providing written notice to FCCPT.***

EXPIRATION DATE: _____
(MM/DD/YYYY)

THIS FORM WILL NOT BE PROCESSED WITHOUT A VALID NOTARIZATION

Notary Seal:

Notary Signature: _____ **Date:** _____
(MM/DD/YYYY)

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