AUTHORIZATION TO RELEASE PERSONAL INFORMATION

I, [*insert individual's full name and address*] _____
_____ whose date of birth is _____,
and whose social security number or ACT ID number is _____,
hereby 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, and to discuss any information relating to those records, to the following individual(s) or institution(s):

RECORDS DEPOSITION SERVICE, INC.

Name of individual or institution to whom ACT is authorized to release information

P.O. BOX 5054, SOUTHFIELD, MI 48086-5054
P: 248-357-3330 F: 248-357-3337

Name of individual or institution to whom ACT is authorized to release information

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

Signature: _____ Date: _____

If the above-named individual is under the age of 18, the parent or legal guardian of the individual must also sign below indicating consent and agreement to this AUTHORIZATION TO RELEASE PERSONAL INFORMATION.

Signature of Parent
or Legal Guardian: _____ Date: _____

Please complete and send to:

Attn: Records Department
ACT, Inc.
301 ACT Drive, P.O. Box 168
Iowa City, IA 52243-0168
Phone: 319-337-1313
Fax: 319-337-1616