HIPAA CONSENT FORM

Authorization (consent) to permit the use and disclosure of identifiable medical information (protected health information).

Candidate Name:

_____

Candidate Birthdate:

_____

By signing below you accept the following policies:

1. You attest to the fact that the information recorded on this application is true, and if this application is not sufficient, you agree to provide Exam Master with any additional information or documentation requested in order to evaluate your request for accommodation. If sufficient or complete documentation is not provided you understand that your request for accommodation will be denied by Exam Master staff.
2. You authorize your diagnostician (whether a physician or other provider) to release any necessary medical information to support and/or verify your requested accommodation(s).
3. You further grant permission for your diagnosing professional to discuss with Exam Master staff your records and history in as much as they relate to the requested accommodation(s) for your test administration.
4. Candidate information will be kept secure and confidential except as is necessary to determine the accommodation request for the test administration. Your information may be retained only as it applies to your administration of the test. Your records will not be available to persons other than Exam Master staff and administrators necessary to determine your accommodation(s). You agree to the procedures utilized by Exam Master for the purpose of determining and providing your request for accommodation.
5. You acknowledge that any submitted information may also be used deidentified for research purposes, and that in no case will any individual be identified by name in research studies.
6. Exam Master staff will notify you of your request by email, U.S. mail, or by any other means. We may send you other communications informing you of changes to your accommodation request.
7. Your information will not be used for the purposes of marketing or advertising of products, goods, or services.
8. You have the right to request restrictions in the use of your protected health information. However, Exam Master is not obligated to alter internal policies to conform to your request.
9. You understand and agree that Exam Master staff may provide your records to an appropriate professional selected by Exam Master for an independent evaluation relating to your request or to the organization or agency for which the exam is administered.
10. You understand and agree that additional accommodations cannot be added to existing registrations. All requested accommodations must be listed and included on your online registration form.
11. You agree to bring any concerns or complaints regarding any privacy matter to the attention of Exam Master.
12. Exam Master may change, add, delete, or modify any of these provisions.

I hereby consent and acknowledge my agreement to the terms set forth above in the HIPAA Consent Form and any subsequent changes.

Signature: _____ Date: _____

Licensed Professional Evaluation Form

To Be Competed Only By A Licensed Professional

Exam Candidate Name:	
Licensed Professional (print your name):	
Address:	
City, State, Zip:	
Phone Number:	Email:
License Number:	State of Licensure:
Board Certification:	
Signature of Licensed Professional Evaluator:	Date:
Licensed Professional's Title:	

**Evaluation on second page. Use additional pages as needed.*

Licensed Professional Evaluation Form

1. I have known _____ (candidate) since _____ (date) in my capacity as a _____.

   The candidate has been diagnosed with the following disability/disabilities:

_____
_____
_____
_____

2. The candidate or Exam Master staff has discussed with me the nature of the PA-CAT exam to be administered. Describe the functional limitation(s) resulting from the impairment(s) as it applies to taking standardized multiple-choice tests:

_____
_____
_____
_____
_____
_____

3. Based on my professional assessment of the candidate's disability/disabilities, the candidate should be accommodated with the following accommodation(s) during the PA-CAT exam. Rational must be included.

Accommodation Requested	Rational of the Accommodation

Signature of Licensed Professional Evaluator: **Date:**

_____ _____

Licensed Professional's Title: **State of Licensure and License Number:**

_____ _____