National Association of Boards of Pharmacy

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Authorization for the National Association of Boards of Pharmacy to Release Information to Designated College of Pharmacy

First Name _____Middle Name _____ Last Name _____

Former Name(s) _____

Date of Birth _____ Identifier_____
SSN (or last four digits) or NABP e-Profile ID (received at NAPLEX/MPJE Registration)

E-mail Address _____ Phone Number _____

1. I voluntarily release and agree to provide to the National Association of Boards of Pharmacy® (NABP®) my full name, all former names, my date of birth, my Social Security number (or last four digits) **or** the NABP e-Profile ID, which are set forth herein, and I authorize NABP to utilize such information for the purpose of confirming my identity and my North American Pharmacist Licensure Examination®` (NAPLEX®) score and, if requested, my Multistate Pharmacy Jurisprudence Examination® (MPJE®) score. I further authorize NABP to release such identifying information to the school or college of pharmacy described herein.

2. Additionally, I authorize NABP to release my MPJE score, if applicable, my overall NAPLEX score, as well as the NAPLEX scores I achieved in the three areas of competency, to the Registrar of the University of Florida School/College of Pharmacy, at POBox 100495/ Gainesville, FL 32610 [address].

3. Except as otherwise permitted or in the event that NABP is legally required to disclose the information that I provide and authorize, NABP will keep confidential and will not disclose any of the information that I release and authorize for use pursuant to this authorization to release form (hereinafter "Form"). This paragraph will survive expiration or revocation of this Form.

4. The University of Florida School/College of Pharmacy has informed NABP that it will not use for commercial or solicitation purposes any of the information that I release or authorize for use pursuant to this Form.

5. NABP disclaims all liability and responsibility arising from this Form except to the extent that NABP breaches its responsibilities or is negligent in performing under this Form and only to the extent that the liability or responsibility is caused by such breach or negligent performance. Further, NABP disclaims all liability and responsibility for individuals' or entities' use, maintenance, or disclosure of the information described in the Form, after NABP's valid release of such information.

6. I understand that I may revoke this Form at any time if I sign and send a letter, via certified, registered, or overnight mail with return receipt requested, to the Executive Director/Secretary, National Association of Boards of Pharmacy, 1600 Feehanville Drive, Mt Prospect, IL 60056, or such other address where NABP may be located at the time of sending such letter. Unless I revoke this Form, it is valid for 18 months from the date that I sign the Form.

I, (Print Name) _____, certify that the information I provided herein is true and accurate, and that I have read, I understand, and I hereby agree to the terms of this authorization to release form.

_____ _____
Signature Date