

SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
5735 47^H Avenue
Sacramento, CA 95824

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION

Name of Student (list other names used) Medical Record Number (if applicable) Date of Birth

Address of Student Phone Number Other Phone Number

I authorize the following individual or organization to disclose the above named individual's educational information as described below:

Individual or Organization Disclosing Information:

Individual or Organization Receiving Information:

Disclosing Party

Receiving Party

Address

Address

City, State, Zip Code

City, State, Zip Code

Phone Number Fax Number

Phone Number Fax Number

Duration: This authorization shall become effective immediately and shall remain in effect until _____ (date) for one year from the date of signature if date is entered.

Revocation: I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the releasing agency. Written revocation will be effective upon receipt, but will not apply to