

SACRAMENTO CITY UNIFIED SCHOOL DISTRICT  
5735 47<sup>H</sup> 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