## SACRAMENTO CITY UNIFIED SCHOOL DISTRICT 5735 47<sup>TH</sup> Avenue Sacramento, CA 95824

## AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION

Name of Studen	nt (list other names used)	Medical Record Number (if applicable)	Date of Birth
Address of Student		Phone Number	Other Phone Number
I authorize the fo	llowing individual or organization to disclose	the above named individual's medical/edlosc(l)(l)1(e	)3(c/1(e)3(os)52N)1.3(on t)18RFcleivsing Pade
		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) or for one year from the date of signature if no 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 information that has already been released in response to this authorization.		
Redisclosure:			