SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
5735 47TH 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 medical/edlosc(l)(l)1(e)3(c/1(e)3(os)52N)1.3(on t)18Tc i s Receiving Party

	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: