



San Francisco Unified School District
Authorization for Release of
Confidential Information

Student's Name: _____ Date of Birth: ___/___/___

School/Dept: _____ Address: _____

Contact Person: _____ Title: _____ Telephone: _____

I authorize the exchange of information described below between the San Francisco Unified School District and the following agency(s) and/or individual(s):

- Healthcare provider(s) (name)
Agency(s) (name)
Parent/ legal guardian (if minor consented to care) (name)
Other

This authorization applies to the following information: (check each line that applies)

- Educational Data/IEP Social/Developmental Psychological
Vision Speech/Language Audiological
Medical Other

Expiration: This authorization expires (date or event): _____

Restrictions: Providers who receive this information may not release it to someone else unless another authorization form is signed.

Your Rights: You may refuse to sign this form. You may cancel it at any time by informing the San Francisco Unified School District in writing. If you cancel your permission to allow the release of information about you/your child, it will go into effect immediately (unless someone already released information). You have a right to receive a copy of this Authorization.

Signature _____ Date _____

Indicate relationship to student: parent legal guardian: