West Contra Costa Unified School District
Pupil Services Center
2465 Dolan Way, San Pablo, CA 94806
Telephone: 510-741-2801 Fax: 510-724-8829

AUTHORIZATION FOR RELEASE OF INFORMATION

A. Student/Patient Information

Name: _____ Date of Birth: _____

Home Address: _____

Telephone Number: _____ Medical Record Number (if applicable): _____

Previous School: _____ Present School: _Transition Program_____

B. Educational/Health Information to be Released From

Agency/Person: _____

Address: _____

F. Expiration of Authorization

Unless otherwise revoked, this Authorization is effective upon my signing and shall expire _____ (insert date or event). If no date is indicated, this Authorization will expire twelve (12) months after the date of signing this Authorization.

G. Signature

By signing below, I authorize the disclosure and use of the educational/health information specified above, and further acknowledge that I have read and understand the Authorization Restrictions and Rights.