

**AUTHORIZATION FOR
RELEASE OF
CONFIDENTIAL INFORMATION**

Student Name : _____ D.O.B. : _____

School: Santa Cruz Valley Unified School District #35
1374 W Frontage Rd.
Rio Rico, AZ 85648

Confidential Information requested by:

Authorized District Employee Title/Position

Confidential Information requested from:

School/Agency/Organization

Address City/State/Zip

I authorize the release of all MEDICAL, EDUCATIONAL, SOCIAL, and PSYCHOLOGICAL INFORMATION that has been made part of the confidential records of the above named student to the requesting party. I understand that this information will be used in a confidential and professional manner and in the best interest of the student. I also understand that all information will be maintained in accordance with the Family Educational Rights and Privacy Act. I am aware that my consent is voluntary and may be revoked in writing at any time.

Signature of Parent/Legal Guardian Date