WRITTEN CONSENT

UNIVERSITY OF CALIFORNIA, SAN DIEGO

_____

DEPARTMENT NAME

AUTHORIZATION FOR RELEASE OF STUDENT INFORMATION

Name:_____ Date of Request:_____

PID:_____ Phone Number:_____

E-Mail Address:_____

I request/authorize that the following information from my educational record

_____

_____

_____

_____

be released to

_____

_____

I hereby acknowledge and understand that the above information will be released to the stated individuals and/or departments on the following basis:

_____One time only

_____Until the end of the current academic year (June 20, 20___)

_____Until this authorization is rescinded by me (no expiration date)

I further understand that if at any point in time I wish to change or rescind this authorization, I must make an additional request.

_____ _____

Signature Date

Revised 2-5-13