City College of San Francisco
Disabled Students Programs & Services

AUTHORIZATION FOR RELEASE OF INFORMATION (AFROI)

Student's Name _____ _____ _____
Last First Middle Initial

Maiden Name or Other Used _____ _____ _____
Last First Middle Initial

CCSF ID# _____ Date of Birth _____
Month/Day/Year

I, the undersigned, consent to and request that the parties named below exchange and discuss information regarding my educational and vocational plans, which may include testing and evaluation results. I further understand that the information shared among the parties will remain strictly confidential.

_____ _____
Name Agency/Department

_____ _____
Name Agency/Department

_____ _____
Name Agency/Department

_____ _____
Signature of Student Date

_____ _____
Signature of Parent or Guardian (required for students under 18 years of age) Date