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/authorized 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 30, 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  __ Until this authorization is rescinded by me (no expiration date)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