

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