COASTLINE COMMUNITY COLLEGE

RELEASE STATEMENT

I hereby request and authorize Coastline Community College to release any medical, psychological, social and/or educational records and testing information and to consult with the following parties regarding my progress and performance at Coastline:

Name/Title: _____

Relationship (Parent, sibling, doctor, etc): _____

Address: _____

_____

Phone #: _____ Cell Phone #: _____

Email Address: _____

Print Your Name: _____

Signature: _____ Date: _____*

Signature of Parent or Guardian if under 18: _____

** this release shall remain in effect for one year from signing*