CAL MARITIME

Student Health Center
California State University Maritime
200 Maritime Academy Drive
Vallejo, CA 94590
Phone: 707-654-1170
Fax: 707-654-1171

Patient Name:_____
Address:_____
City:_____State:_____Zip:_____
Phone:_____DOB:_____

I authorize release from:

(Name of **disclosing** party):

Name:

_____

Address:

_____

City:

_____

State: Zip:

_____ _____

Phone: Fax:

_____ _____

To release to:

(Name of **receiving** party):

Name:

_____

Address:

_____

City:

_____

State: Zip:

_____ _____

Phone: Fax:

_____ _____

Specific Dates (if applicable):_____

Please check box(es) below for specific information to be released:

☐ General Medical Records _____ Signature Date

☐ Psychiatric Records (Excluding C.A.P.S.) _____ Signature Date

☐ Drug/Alcohol Treatment _____ Signature Date

☐ HIV Test Results _____ Signature Date

☐ Other:_____ _____ Signature Date

_____

_____

☐ Please mail the records.
☐ Please fax the records.
☐ I will pick up the records.

Purpose of this release is for:

☐ Continuity of care
☐ Other: _____

_____

_____

My consent may be revoked at any time. Unless previously revoked, this authorization will terminate one year after the date of my signing. Each disclosure requires an additional signed authorization. Only original signed requests are valid. I understand the copy fee is $0.25 per page of 5 or more pages. I understand I have the right to receive a copy of this authorization.

_____ _____

Signature of Patient/ Legal Representative Date

Name of Legal Representative & Relationship to Patient

For Office Use Only:
ID Verified by:_____ Record Release (circle one): Approved Denied
Fee Due:_____ Director, Student Health Center
Processed by:_____ Signature:_____Date:_____