



**Student Health Center**  
**Cal Poly Maritime Academy**  
**200 Maritime Academy Drive**  
**Vallejo, CA 94590**  
**Phone: 707-654-1170**  
**Fax: 707-654-1171**

I authorize release from:  
(Name of **disclosing** 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:\_\_\_\_\_