CAL MARITIME

Student Health Services
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:_____SID:_____

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
☐ Psychiatric Records
☐ Drug/Alcohol Treatment
☐ HIV Test Results
☐ Other

_____ Signature Date
_____ Signature Date
_____ Signature Date
_____ Signature Date
_____ 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 consent will terminate six months after the date of my signing this consent. Each disclosure requires an additional signed authorization. Only original signed requests are valid. I understand the copy fee is $0.25 per page copied of 5 or more pages.

_____ Date
Signature of Patient
(Parent/Guardian if patient is under 18)

_____
Relationship to Patient
(If signed by other than patient)

For Office Use Only: Sign and Date

ID Verified by:_____
Fee Due:_____Collected:_____

Record Release Approved by:_____
Processed by:_____