

Information Release Authorization

I,	•
I,Student's Name	Student ID #
authorizeName of hospital, clinic, school, or agen	
Name of hospital, clinic, school, or agen	cy
or its director, designee, or records department, to releas the individual or organization listed below:	se the information contained in my records to
Dr. Vivienne McClendon, Director Disability Services Office The California Maritime Academy 200 Maritime Academy Drive Vallejo, CA 94590	
Specific type of information to be disclosed: Psychological, vocational interest, and ap Medical records of treatment for physical including treatment records for substan	and/or emotional illness
For the purpose of: Establishing eligibility for academic acco Other (please specify):	
Signature	 Date

(FORM 104)