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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Purpose of this disclosure: Documentation, verification, and support for Accessibility and Disability Accommodations

I authorize Counseling and Psychological Services (CAPS) to release/exchange information contained in my counseling record between CAPS and:

Cal Maritime Student Health Services medical providers

Name: Dr. DeAna Vides, Disability Coordinator

Organization/Agency: Cal Maritime Accessibility and  
Disability Services Office

Address: 200 Maritime Academy Drive

Phone: (707)6541562 E-mail: [dvides@csum.edu](mailto:dvides@csum.edu)

City: Vallejo State: CA Zip: