Special Programs and Services

AUTHORIZATION TO RELEASE RECORDS

Student's Name:_____ Date of Birth:_____

Address:_____

_____

Student ID #:_____

I request and authorize:

Name:_____ Company:_____

Address: _____

_____

Phone:_____ Fax:_____

Email: _____

to release my records to:

Coastline College

Special Programs and Services

1515 Monrovia Avenue, Newport Beach, CA 92663

Phone: 714-241-6214, Fax: 714-431-3602

specialprograms@coastline.edu

This request and authorization applies to information relating to the following treatment(s), condition(s), and dates if applicable:

☐ Medical (include films and x-rays) Dates:_____

☐ Educational (include testing data) Dates: _____

☐ Psychological (include testing data) Dates:_____

☐ Drug/Alcohol Abuse Treatment Dates:_____

☐ Vocational Dates:_____

☐ Other _____ Dates:_____

Student Signature:_____ Date: _____