# RECORDS RELEASE AUTHORIZATION

TO_____/FROM____

Kathryn Najafi-Tagol, MD
Eye Institute of Marin

4000 Civic Center Dr #200A
San Rafael, CA 94903

Ph: (415) 444-0300
Fax: (415) 444-0301

TO____/FROM____

Name: _____
_____

Address: _____
_____
_____

Ph:_____
Fax:_____

I consent to release the following health information (check all that apply):

Date(s) of treatment:_____

_____ All health care information

_____ Health care information relating to the following treatment or condition

---

The following information will not be released unless the specific item is checked:

_____information pertaining to drug & alcohol abuse, diagnosis or treatment

_____information pertaining to mental health diagnosis or treatment

_____HIV/AIDS test results

_____information pertaining to genetic testing

This authorization shall in force and effect until _____ (date or event), at which time this authorization expires.
I understand that I have the right to revoke this authorization, in writing, at any time.
I understand I have the right to receive a copy of this authorization upon request.
I understand I have a right to request restrictions on the uses and disclosures of health information; however, Eye Institute of Marin/Dr. Najafi-Tagol, it's employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records.

_____

Patient Name (Print) Date

_____

Patient/Guardian Signature Date of Birth

_____

Authorized by Dr. Kathryn Najafi-Tagol