Kat Motlagh's Health Clinics

Katayoun Motlagh, M.D.

PATIENT INFORMATION RELEASE

I (patient name) _____ authorize/do not authorize release of my medical information at any time to (person information being released to) _____

Relationship:

- Spouse
- Guardian
- Other_____

Information to be released:

- All
- Test Results
- Health Status
- Other_____

Please sign and date below:

Witness Signature **Patient Signature** **Date**