



## RELEASE OF RECORDS

(PLEASE PRINT)

I, \_\_\_\_\_,

the undersigned, hereby authorize and direct my therapist:

Therapist Name: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_

to release all personal information pertaining my evaluation and treatment to:

*Dr. Soheil Navidbakhsh*  
**Educational & Awareness Center**  
18345 Ventura Boulevard, Suite 500  
Tarzana, CA 91356

**X**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date