



I _____ hereby authorize _____
(patient name) (physician name)

to release the information contained in this application to the Marin County Department of Health & Human Services, Office of Vital Statistics.

I Further declare that the foregoing information is true and correct, and that this declaration was signed by me on _____
(today's date)

(patient signature)

When you have completed forms signed by your physician, call to set up an appointment 415-473-3288. Bring all forms with required identification to:

Office of Vital Statistics
10 N. San Pedro Rd.
San Rafael, CA 94903
