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AUTHORIZATION TO RELEASE INFORMATION

This form has been created to protect your right to confidentiality. Please note that the form specifies with whom information about you, or your child, may be exchanged and for what purpose. This may be considered to be a reciprocal agreement. All blanks should be filled in before you sign this form.

I AUTHORIZE JASON TAKEUCHI, M.D. TO EXCHANGE CONFIDENTIAL INFORMATION REGARDING _____ WITH **(NAME OF CLIENT)**

Name _____
Address_____

Phone ( ) _____ Fax ( ) _____

FOR THE PURPOSE(S) OF _____ . THIS IS VALID FROM THE DATE SIGNED BUT NOT BEYOND _____.

SIGNATURE OF CLIENT _____ DATE _____

PRINT NAME _____

IF CLIENT IS A MINOR:
SIGNATURE OF PARENT/LEGAL GUARDIAN _____

PRINT NAME (PARENT/LEGAL GUARDIAN) _____

RELATIONSHIP TO CLIENT _____

DATE _____