

**Jason Takeuchi, MD**

1650 Borel Place, Suite #208  
San Mateo, CA 94402  
(650) 348-4900

**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 HEALTH/ MENTAL HEALTH 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** \_\_\_\_\_