**Child & Adult Psychiatrists of the Peninsula**

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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________________________, 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 ____________________**