CATHERINE KUNIYOSHI, M.D.
JON KUNIYOSHI, M.D., Ph.D.
1501 Western Avenue, Suite 110
Seattle, WA 98101
Phone: 206-405-3600 Fax: 206-405-3604

RELEASE AND EXCHANGE OF INFORMATION

I authorize **Catherine Kuniyoshi, M.D and Jon Kuniyoshi, M.D., Ph.D.** to exchange and **obtain verbal and/or written** information with:

To: ______________________________ **Phone:** ______________
Address: ______________________________ **Fax:** ______________

I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnoses.

Specific Information to be obtained and/or exchanged:

- ☐ Medical clinic notes, history & physical reports
- ☐ Treatment notes/Current & past medications
- ☐ Lab reports
- ☐ Treatment plans/Reviews
- ☐ Other (Please Specify)
- ☐ Intake evaluation & assessment
- ☐ Psychiatric evaluation
- ☐ Psychological testing/assessment
- ☐ Educational records & IEP
- ☐ Verbal Exchange

Purpose of Exchange:

- ☐ Transfer of care
- ☐ Treatment Planning
- ☐ Other (Please Specify)
- ☐ Evaluation and treatment services
- ☐ Treatment coordination

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I understand that unless I revoke this authorization, this authorization will expire 1 year from the date this authorization is signed. I understand that re-disclosure of this information is prohibited as required by law.
I understand that authorizing the disclosure of this information is voluntary and I do not need to sign this form in order to assure treatment or payment. I understand that information used or disclosed in accordance to this authorization may no longer be protected by federal law, and could be used or re-disclosed by the receiving entity. I understand that I can cancel this authorization at any time by writing to Catherine and/ or Jon Kuniyoshi, M.D., although I understand that once the information has been released that the information cannot be recalled.

MINOR CONSENT:
If a patient is a minor, relevant state law will be followed with respect to the required signatures. Clients ages 13 and above must sign this authorization for care of substance abuse diagnosis or treatment as well as mental health information. Clients ages 14 and above must sign this authorization for information concerning birth control, pregnancy related care and sexually transmitted disease information (including AIDS/HIV).

ROI is valid for one year from date signed

Signature of Legal Representative:______________________ Date Signed: ______________
Relationship to Patient

Signature of Patient 13+ years ___________________________ Date Signed: ______________

Patients Name (Please Print) : ___________________________Patients DOB: _________