JON J. ATIGA, M.D., INC.
27699 JEFFERSON AVE., STE. 314
TEMECULA, CA 92590

Authorization to Provide Information to Child Care Provider or School Health Officer

_____
Patient Name

_____
Date of Birth

I give authorization for Dr. Atiga's staff to provide any information (written of verbal) regarding services rendered to my child care provider or school health office upon their request.

Please specify any restriction:

_____
Parent or Legal Guardian Signature

_____
Date