East Bay Family Therapy
Marc Komori Stager, Psy.D.

Authorization to Request and/or Release Information

Client Name: _____ Date of Birth: _____

I authorize Dr. Marc Komori Stager and East Bay Family Therapy to exchange information with:

_____
Name of Person or Organization

_____ _____
Street Address Phone

_____ _____
City/State/Zip Code Fax

The information to be disclosed includes:
_____ Medical Records _____Mental Health Treatment/Information _____Drug & Alcohol Information
_____ Psychiatric/Psychological Evaluations _____ Other: _____

The purpose for the release is: _____ Continuity of Care OR Other: _____

Dates include: _____ All dates of treatment OR From _____ to _____

I understand that the information released may include a diagnosis or reference to the following conditions: behavioral health services/psychiatric care; AIDS or HIV; or drug or alcohol abuse. If the information to be released pertains to the diagnosis and treatment of alcoholism and/or drug abuse, I understand that Federal Law 42,CFR Part 2 protects the confidentiality of that information. I understand that treatment, payment, enrollment and eligibility for benefits may not be conditioned on signing this authorization.

I hereby understand that the information disclosed pursuant to this Authorization might be redisclosed by the recipient and may no longer be protected by the Federal Privacy Regulation 45 CFR Part 164. I release the Dr. Marc and EBFT from all liability for disclosing the requested information.

I certify that this Authorization is voluntary and I understand that I may refuse to sign this Authorization. I may revoke this consent at any time by providing written notice, except to the extent that the Dr. Marc or EBFT has already taken action on this request. This Authorization will expire on _____.

_____ _____
Signature of Client or Legal Representative Date

_____ _____
Print Name of Legal Representative Relationship to Client

Revocation of this Authorization

I hereby revoke this Authorization to Request/Release Information:

_____ _____
Signature of Client of Legal Representative Date