

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