

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 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 provider 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 provider 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

Witness

Date

I hereby revoke this Authorization to Request/Release Information:

Signature of Client of Legal Representative

Date