

DIALECTICAL BEHAVIOR THERAPY CENTER OF SAN DIEGO

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AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORDS

The undersigned authorizes the release of the mental health records described below:

Name of Patient: _____

Date of birth: _____ (month) _____ (day) _____ (year)

Person or agency authorized to release information:

Name: _____ Phone: _____

Address: _____ Fax: _____

Name of agency to receive records or information:

Dialectical Behavior Therapy Center of San Diego (DBT Center of San Diego)

I authorize the above named person/agency to release the following information about me to DBT Center of San Diego. Authorization is limited to the information below circled "Yes". I also authorize therapists at DBT Center of San Diego to speak to the above named person or agency regarding the information about me indicated below, for the purpose of coordinating treatment.

No	Yes	Diagnosis	No	Yes	Medical History
No	Yes	Psychological Evaluation	No	Yes	Treatment Plan
No	Yes	Progress Notes	No	Yes	Treatment Summary
No	Yes	Other (specify) _____			

The use of the information released is limited to Assessment and Treatment planning. This authorization is valid for one year from date of signature, except that the patient can revoke authorization at any time.

I release Dialectical Behavior Therapy Center of San Diego and Milton Brown from legal liability arising from the release of this information indicated above.

The undersigned patient has the right to receive a true copy of this authorization. By placing your initial in the space under this paragraph, you acknowledge that a true and correct copy of this authorization has been received. **Initials:** _____

	<u>Name (printed)</u>	<u>Signature</u>	<u>Date</u>
Patient	_____	_____	_____
Legal Guardian	_____	_____	_____
Legal Guardian	_____	_____	_____