

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)

Agency authorized to release information:

Dialectical Behavior Therapy Center of San Diego (DBT Center of San Diego)
9666 Businesspark Ave., Suite 105, San Diego, CA, 92131, (619) 342-8584 / fax

Name of person or agency to receive records or information:

Name: _____ Phone: _____

Address: _____ Fax: _____

I authorize the Dialectical Behavior Therapy Center of San Diego to release the following information about me to above named person/agency. Authorization is limited to the information below circled "Yes"

No Yes I request that therapists at DBT Center of San Diego speak to the above named person or agency regarding the following information about me, for the purpose of coordinating treatment.

No Yes I request that the DBT Center of San Diego send written records to the above named person or agency regarding the following information about me.

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) _____

I release Dialectical Behavior Therapy Center of San Diego and Milton Z. Brown Ph.D 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	_____	_____	_____