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 I initial below:

_______ Diagnosis _______ Medical History

_______ Psychological Evaluation _______ Treatment Plan

_______ Progress Notes _______ Treatment Summary

_______ Other (specify) ____

The use of the information released is limited to assessment and treatment planning, and DBTCSD will not provide copies of the information to the patient.
This authorization is valid for one year from date of signature, except that the patient can revoke authorization at any time.

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:** __________________

	Name (printed)	Signature	Date
Patient	__________________	_______________________________	_________
Legal Guardian	_________________	_______________________________	_________
Legal Guardian	_________________	_______________________________	_________

If you have received this form in error, please immediately notify us by e-mail (dbtsandiego@gmail.com) or telephone (619-602-0726), and permanently destroy or delete the original and all copies of this form.