

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)

Former therapist or hospital 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, unless the patient specifies a different date here: _____

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	_____	_____	_____