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)

Hospital or former therapist 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:** _____

	Name (printed)	Signature	Date
Patient	_____	_____	_____
Legal Guardian	_____	_____	_____
Legal Guardian	_____	_____	_____

Date faxed/mailed: / / by Ready to file away ☐ CF01-ROI.doc ROI-receive - 5/13/12

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