

DIALECTICAL BEHAVIOR THERAPY CENTER OF SAN DIEGO

9666 Businesspark Ave., Suite 105, San Diego 92131
(619) 602-0726 office, (619) 619-609-0707 fax

Milton Z. Brown, Ph.D. (Lic # PSY20785)
www.dbtsandiego.com

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORDS^{bid}

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

Name of Patient: _____

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

Current psychiatrist, therapist, physician, school counselor or other authorized person:

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, unless the patient specifies a different date here: _____

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	_____	_____	_____

AG JL MM KD JW MB MC Date faxed/mailed: / / by Ready to file away ROI-bidirectional - 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.