DBT CENTER OF MARIN
WWW.DBTMARIN.COM

895 Sir Francis Drake Blvd.
San Anselmo, CA 94960
T 415.459.5206
info@dbtmarin.com

Consent to Release Information

I hereby authorize ___________________________________ at the DBT Center of Marin & Oakland, to release my medical information to the individual or organization listed below:

Name:____

Phone:_______________________________________ Fax:__________________________________

Address:____

City/State/Zip:____

This person is my (circle one):

*Therapist *Family Member *Psychiatrist *Primary Care Physician *Case Manager/Social Worker
*Other:______________________

Dates Seen: from______________________________ to _________________________

Reports to be Furnished/Verbal Information Requested:

_____ Psychiatric Evaluation and Assessment Reports ____ Progress and/or Discharge Reports
_____ Treatment Plan ____ Medication Information
_____ Other

This authorization shall remain valid until ______________________________ or for one year (based on signature date below), whichever comes first, and may be revoked in writing at any time. Information released per this Consent will not be further used or disclosed, unless authorized, except where permitted by law. A fax or copy of this document shall be valid.

____
Printed Name of Client

____ ______________________________
Signature of Client Date

____
Printed Name of Legal Guardian (for minors)

____ ______________________________
Signature of Legal Guardian (for minors) Date