DBT of TOWSON
Dialectical Behavior Therapy

AUTHORIZATION TO RELEASE INFORMATION (THERAPIST)

I, _____, give permission to DBT of TOWSON

To discloseto/receive from _____ the
Therapist's Name & Phone Number

following information: *patient attendance, treatment progress, notice of discharge, and/or any other relevant treatment-related information*.

The purpose or need for such disclosure is: *continuity of care*.

This information may be given: *as needed*.

This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon, and will otherwise expire on: _____.

NOTICE TO RECIPIENT OF INFORMATION:

This information has been disclosed to you from records whose Confidentiality is protected by federal law. Federal Regulation (42 CFR – Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A General Authorization for the release of medical or other information in NOT sufficient for this purpose.

_____ _____
Patient Date

_____ _____
Witness Date

408 Allegheny Avenue
Towson, MD 21204

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