Denver DBT and Psychotherapy, INC

Consent to Release of Information

I hereby authorize my provider at Denver DBT and Psychotherapy, INC to release and obtain information during the course of treatment to the following:

Name

Telephone

Relationship

I agree that the medical information obtained pursuant to this authorization may be utilized for the purpose of processing claims for payment, explaining billing statements and services provided, aiding in continuing care and treatment, and facilitating understanding and support in recovery. This authorization shall become effective immediately and shall remain effective until the date upon which the patient shall no longer receives services from Denver DBT and Psychotherapy, INC. Patient/guardian has the right to revoke this consent at any time, providing no action has been taken in reliance upon this form.

Client Name, Printed

Client (Parent/Guardian) Signature

Date

Typing your name above will stand in for the signature.

Clinician Name, Printed

Clinician Signature

Date