St. Louis DBT, LLC

RELEASE OF INFORMATION

Sending/Receiving Information

St. Louis DBT, LLC is committed to protecting the privacy of all clients as completely as possible. However, in some cases, it is necessary or desirable for us to either receive and/or to share information with others. The purpose for obtaining and/or sharing this information is to ensure proper professional mental health services. This authorization complies with the HIPAA Privacy Rule and permits health care providers and other covered entities to disclose personal health information.

___I grant St. Louis DBT, LLC permission to ☐ **SEND** ☐ **RECEIVE** information about me and my case as deemed appropriate to provide adequate and quality treatment. I grant St. Louis DBT, LLC permission to provide this information:

( ) one time only
( ) for a limited time period of: (circle one) 90 days / 6 months / 1 year

I grant St. Louis DBT permission to send and/or receive information about me and my case, as checked above, to the following:

Name:

Agency/Organization:

Relationship:

Address:

Phone: Fax:

I hereby give my authorization and consent for you to release my ☐**Discharge Summary** ☐**Discharge Staffing** ☐**Treatment Plan** ☐**Treatment Summary** ☐**Diagnosis** ☐**Progress Notes** ☐**Assessment** ☐**Psychiatric Evaluation** ☐**Photos**☐**Med Administration Records** ☐**Record Abstract** ☐**Patient Review** ☐**Social History** ☐**Behavior Plans**☐**Consultations** ☐**Physicians Orders** ☐**Labs** ☐**X-Rays** ☐**Other**____

The release of this information may be made by mail or fax. By my signature, I acknowledge that any prior agreements I have made to restrict my personal health information do not apply to the information released under this authorization.

This consent and authorization for the release of information is subject to revocation at any time, except to the extent that action has already been taken thereon. In any event, this authorization shall cease without further communication from me as of the end of the time period circled above.

I initiate this authorization for disclosure of personal health information. I have read and understand this authorization. You are hereby authorized to accept a facsimile or photocopy of this release, the same as an original.

Client Name ____

Client Birth Date ______________________Social Security Number ___________________

Client Signature ____Date _______________

Parent/Guardian Signature ____Date _______________

Therapist Signature ____Date _________________________