



AUTHORIZATION TO RELEASE INFORMATION

I, _____, give permission to DBT of TOWSON

To disclose to/receive from _____ the
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 is NOT sufficient for this purpose.

Patient

Date

Witness

Date