DBT CENTER OF LAWRENCE
AUTHORIZATION FOR RELEASE AND OBTAINMENT OF INFORMATION

A release of your Protected Health Information (PHI) is required in order for the DBT Center of Lawrence to collaborate with other professionals or talk with anyone about you or your care to coordinate care with the individual/institution listed below during the course of your treatment. We ask you to complete this form for any individual (spouse, parent, guardian, other providers, etc.) whom you consent to have your information released, either verbally or in writing. This includes written records, verbal communication, or information shared via text or email. You can also find this form on our website: www.dbtlawrence.com.

Parents and Guardians. In order for us to speak with parents and guardians on behalf of their child (age 18 or older) about their PHI, *we are required to have the client's written consent*.

PERSON COMPLETING THIS FORM (YOURSELF OR ON BEHALF OF DEPENDENT FOR WHOM YOU ARE GUARDIAN)

_____
First Name Last Name Date of Birth

_____
Address City State Zip Code

I authorize the release and/or obtainment of the following (mark any that apply):

RELEASE	OBTAIN		RELEASE	OBTAIN		RELEASE	OBTAIN	
☐	☐	Billing/Financial		☐	Lab/EKG	☐	☐	Psychological tests, assessments, evaluations
	☐	Crisis screening report	☐	☐	Legal Information	☐	☐	Safety Plan
	☐	Custody Evaluation		☐	Medical discharge summary	☐	☐	Scheduling
☐	☐	Diagnosis/Prognosis		☐	Medication record	☐	☐	Substance abuse information
☐	☐	Educational records		☐	Physician's orders	☐	☐	Treatment Plan
	☐	HIV/AIDS status	☐	☐	Presence in treatment	☐	☐	Other: _____
☐	☐	Intake Evaluation	☐	☐	Progress/Therapy Notes			

THE DBT CENTER HAS PERMISSION TO RELEASE/OBTAIN INFORMATION FROM THE FOLLOWING:

_____
Name or "Staff" Relationship to Client/Organization Name Address

_____
City State Zip Phone Fax Email*

*By providing an email address for this individual, you agree to release the DBT Center of Lawrence to use this method of communication with this individual by email and understand that these communications may not be completely secure while using the Internet. Do not provide an email address if you do not want this form of communication used.

AUTHORIZATION

I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulation. This authorization is valid until 90 days after my chart is closed at the DBT Center of Lawrence or until such time as I provide written revocation and it has been received by the DBT Center of Lawrence, or by:____ / ____ / _____.

In addition, I understand that revoking this authorization at any time will not affect any action taken in reliance of this authorization before the written revocation was received. If signing authorization as Power of Attorney, Power of Attorney for Health Care or Guardian/Conservator, a copy of the legal document must accompany this form.

_____
Client/Parent/Guardian/Personal Representative Signature Printed Name Date

_____
Witness Signature Printed Name Date

Client ID: _____ DOB: ___/___/_____ Legal Name: _____