The Auburn-Davis Center for
Dialectical Behavior Therapy

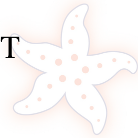
13620 Lincoln Way Suite 380
Auburn, CA 95603

129 C Street Suite 7
Davis, CA 95616

Authorization to Release Information

I ____ authorize the following DBT

Therapist/s:



Susan Landes PsyD, MFT	Patrick Yamamoto, MFT
Lisa Anderson, MFT	Dayle Rodenborn, LCSW
Nina Strom, MFT	Erin Auvinen, Counselor
Sundas Pasha, Intern	Derek Naccarato, Intern

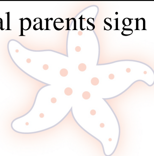
to disclose mental health treatment information obtained prior to and during the DBT Program among themselves and with:

Psychiatrist/Therapist Name:
____(circle one): PhD, MD, LCSW, MFT
Street ____ Room or Suite:___________
City: __________________________State:________ ZIP: _____________
Phone: ________________________ FAX: _________________________
Email: ____

I understand that I have a right to receive a copy of this authorization if I request it. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. Such revocation must be in writing and received by a ADCDBT staff member at the address below to be effective.
I am allowing these parties to exchange written or verbal information from
________________ until
Today's Date
one year after the completion of the DBT Program in which I participate. The objective of the exchange is to coordinate treatment planning.

Consent Signature ______________________________________
Consent Signature ______________________________________
Consent Signature ______________________________________
Printed Names ____
Date ___________________

Participants under the age of 18 must have both legal parents sign as well for a total of three signatures



AuburnDavisDBT.com 530-888-9858