



Authorization to Release Information

I _____ authorize the following DBT

Therapist/s:

Susan Landes PsyD, MFT
Lisa Anderson, MFT
Nina Strom, MFT
Sundas Pasha, Intern
Emily Gosnell, Intern
Jennifer Knight, Intern



Patrick Yamamoto, MFT
Dayle Rodenborn, LCSW
Erin Auvinen, Counselor
Derek Naccarato, Intern
Bonnie Martello, MFT

to disclose and receive 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

