WAYNE STATE UNIVERSITY
Psychology Clinic

DIALETICAL BEHAVIOR THERAPY PROGRAM: AUTHORIZATION RELEASE

RE _____

Date of birth _____-_____-_____

This form, when completed and signed by you, authorizes the WSU DBT Program to release and obtain protected information from your clinical record to the person you designate.

I authorize my clinician(s), _____ and/or their

administrative and clinical staff _____ to release and

obtain general information about my current and past mental health, as well as my treatment attendance history. I am requesting my clinician to release this information in order to determine eligibility and appropriate fit for the WSU DBT Program, as well as coordinate ongoing care between the individual clinician and the WSU DBT Program.

Disclosure

Please provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.

This information should only be communicated between (name and address of persons to whom the information is to be communicated).
Name: Wayne State University Psychology Clinic
Address: 5229 Cass Ave, Detroit, MI 48202
Phone: 313-577-2840

Clinician name _____

Clinician address _____

Clinician phone _____-_____-_____

This authorization shall remain in effect until _____ or until (*fill in an event that*

relates to the individual or the purpose of the use or disclosure): _____

_____.

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You have the right to revoke this authorization, in writing, at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Consent

I understand that my clinician generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA privacy rule.

Signature of patient/parent/guardian _____

Printed name _____

Date _____-_____-_____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.