Tampa Bay DBT Counseling Center
6938 W Linebaugh Ave, Suite 101
Tampa FL 33625
Phone 443-621-0976 Fax 813-265-0586

I, _____, Date of Birth: _____a legally competent adult, hereby authorize Tampa Bay DBT Counseling Center to release and exchange information contained in my mental health record with:

Name: _____

Organization: _____

Address: _____

_____

Phone: _____ Fax: _____

I approve and authorize release of the following:

___ Psychotherapy Summary Report

___ Treatment Plan

___ Mental Status Report

___ Entire Record

___ Verbal and Written Communication

___ Other (specify) _____

The above information will be used for the following purpose:

___ Planning and continuing appropriate treatment

___ Determining eligibility for benefits or programs

___ Case review

___ Continuity of care

___ Other (specify) _____

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

_____ _____
Signature of Client or Legal Representative Date

_____
Printed Name

_____ _____
Signature of Witness Date

_____
Printed Name