METRO NY DBT
CENTER

ADOLESCENT RELEASE OF INFORMATION

I, _____ , the legal guardian of _____ , give permission for this therapist to receive and share the following information:

☐ All written reports
☐ Individualized Education Program
☐ Verbal Reports
☐ Medical Reports

This information will be received from/shared with the following:

_____

_____

_____

This authorization will expire on: _____.

I understand that I may refuse to sign this form and I may revoke authorization at any time by informing the therapist.

Signature: _____

Date: _____

Clinician Name: _____

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