METRO NY DBT
CENTER

ADULT RELEASE OF INFORMATION

I, _____ , 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: _____

NEW YORK OFFICE: 16 W. 86th Street, Suite #1A | New York, NY 10024
NEW JERSEY OFFICE: 205 Ridgedale Avenue | Florham Park, NJ 07932
212-560-2437 | info@MetroNYDBT.com