Standard Authorization
For Sharing of Medical and Mental Health Information

I, _____ [Name of Patient/Client],

whose Date of Birth is _____ , authorize DBTweens to disclose to and/or obtain from:

_____ [Name of Medical Provider/PCP]

Medical Provider/PCP's email: _____ Phone : _____

Mailing address: _____

Description of Information to be Disclosed (Patient/Client should initial each item to be disclosed)

_____ Assessment _____ Diagnosis _____ Psychosocial Evaluation _____ Psychological Evaluation
_____ Psychiatric Evaluation _____ Treatment Plan or Summary _____ Current Treatment Update
_____ Medication Management Information _____ Presence/Participation in Treatment
_____ Nursing/Medical Information

Purpose

_____ Educational Information _____ Discharge/Transfer Summary _____ Continuing Care Plan
_____ Progress in Treatment _____ Demographic Information _____ Psychotherapy Notes*
_____ Other _____ _____ Other _____
(*Cannot be combined with any other disclosure)

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. If the purpose is other than as specified above, please specify:

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to DBTweens. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires in 12 months.

continued...

Standard Authorization For Sharing of Medical and Mental Health Information (contd.)

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-Disclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

_____ _____

Signature of Parent,
Guardian or Personal Representative

Date