

Request / Authorisation to Release Confidential Records & Information

I authorise DBT Clinics Australia to request and receive confidential clinical records and information about me with the person or organisation identified below, for the purpose(s) and information categories I select on this form.

A. CLIENT DETAILS

First name Surname
Date of birth Home address

B. PERSON / ORGANISATION AUTHORISED TO EXCHANGE INFORMATION

Person or organisation
Address
Phone Email

C. PURPOSE OF RELEASE / EXCHANGE

☐ Further mental health evaluation, treatment or care

☐ Further treatment or service planning

☐ Other:

D. INFORMATION AUTHORISED FOR RELEASE / EXCHANGE

☐ Medical history and evaluation(s)

☐ Educational records

☐ Mental health evaluations

☐ Progress notes and treatment / closing summary

☐ Developmental and/or social history

☐ Psychological and psychiatric reports

☐ Other:

E. CONSENT & AUTHORISATION

I confirm that this request / authorisation has been explained to me and that I understand the nature of the records and information, their contents, and the possible consequences of their release. This authorisation is voluntary. I understand that I may withdraw my consent at any time, except where action has already been taken in reliance on it. Unless withdrawn earlier or the stated purpose has been fulfilled, this authorisation expires 12 months from the date it is signed.

Name

Signature

Authority

☐ Client

☐ Parent

☐ Guardian

☐ Other