Megan Gewitz, LCSW **119 W. 57th St.**
DBT Therapist **Suite 1100**
Transcend Behavioral Health **917-442-7592**

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name ________________________________ DOB______________________

I authorize Transcend *Behavioral Health* to obtain information from &
release information to:

Person/Agency/School____

Telephone number ____

Address, City, State ____

The specific information to be disclosed is:
____ Diagnosis Only
____ Beginning and End Dates of Treatment
____ Psychological Assessment/Testing Information
____ Verbal/Written Communication Regarding Treatment
____ Termination Summary
____ Other (specify)____

This information will be used for the following purpose(s):
____ Evaluation and Continuing Treatment
____ Coordination of Care
____ Educational Placement/Other Educational Purposes
____ Other (specify)____

I understand that I have the right to revoke this authorization at any time. The revocation will not apply to any information that has already been released in response to this authorization. This authorization will expire one year from the date of the signature below and may be used until such time for either a one-time release or periodic release of information. I also understand that authorizing the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have the right to receive a copy of this authorization upon my request. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by the federal privacy rules or by state law.

Signature of Client or Legal Guardian______________________________

Date _____________________Relationship to Patient ________________

Signature of Witness___________________________ Date____________