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DBT Skills Class: Client Release of Information

Client Name: ____

Phone #: ____

Email: ____

Primary Therapist: ____

Phone #: ____

Email: ____

Class Day and Time: ____

I authorize full communication and the release of any pertinent medical information between my therapist and Peachtree DBT / Peachtree Psychiatric Professionals. I understand I will not be eligible to participate in the Peachtree DBT Skills Training Program unless I regularly attend individual therapy sessions on an on-going basis. **There will be a case management fee for all clients with an external primary therapist.**

Patient Signature: __________________________________**Date:** ______

Parent/Guardian Signature: ________________________________**Date:** ______

Witness Signature: ____**Date:** ______

After submitting this form to our office, the skills training instructor will contact your primary therapist to establish an open line of communication in order to discuss the client's diagnosis and any important clinical information.