AUTHORIZATION TO RELEASE INFORMATION
Integrated Health Services, Inc., DBT of Southern Oregon
Phone 541-621-0303 Fax 458-226-2072

Client Name: _____ Date of Birth: _____

Email address where initial insurance verification and insurance coverage changes can be sent: _____

Email address where I can be reached for video therapy sessions: _____

Cell phone number where text messages can be sent (for DBT group purposes only):

_____

Please initial the following statements:

I authorize DBT of Southern Oregon and it's administrative staff to send insurance information (specifically my initial insurance verification and when my insurance coverage changes) to me via email _____

I consent to receiving emails from DBT of Southern Oregon for insurance purposes only and I understand that this is not a confidential form of communication _____

I authorize DBT of Southern Oregon and it's therapists to use my email to initiate video therapy sessions _____

I authorize DBT of Southern Oregon and it's therapists to send group information (specifically group homework) to me via text _____

I consent to receiving texts from DBT of Southern Oregon and it's therapists and I understand that this is not a confidential form of communication _____

Signature of Client: _____ Date: _____

Signature of Parent, Guardian or Representative: _____ Date: _____