Penn Medicine

Hospital of the University of Pennsylvania

Department of Psychiatry
Outpatient Psychiatry Clinic

# Consent for Communication of Medical Information Including Mental Health

***THIS IS NOT FOR COPYING YOUR MEDICAL RECORDS***

Name: _____ Date of Birth: _____

The purpose of this disclosure authorization is to improve assessment and treatment planning, share information relevant to my treatment, and when appropriate, coordinate treatment services.

I authorize the Clinical Practices of the University of Pennsylvania, Department of Psychiatry

☐ to release information to:
☐ to obtain information from:

Name of Provider, Facility, or Other Person

_____

Address

_____

City, State, Zip Code

_____

Phone #/Fax # (include area code)

Outpatient Psychiatry Clinic
3535 Market Street 2nd Floor
Philadelphia, PA 19104
Appts 215-746-6701
Fax 215-573-5668

TYPE OF COMMUNICATION MAY BE WRITTEN AND/OR VERBAL FROM THE ONSET OF MY TREATMENT:

☐ Communication regarding my medical/psychotherapeutic/psychopharmacological treatment
☐ Other information (please specify) _____

AUTHORIZATION is VALID FROM ___/___/___ to ___/___/___ (not to exceed one year).

*I understand:*

- The purpose of this authorization is to improve assessment and treatment planning, share information relevant to my treatment, and when appropriate, coordinate treatment services.
- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time during the authorization period either verbally or by sending written notification to the Operations Manager,3535 Market Street, 2nd FL, Philadelphia, PA,19104.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- This release includes mental health related care and substance abuse diagnosis and treatment information.

_____
Printed Name of Patient

_____ _____ _____
Patient's Signature Date Time

_____ _____ _____
Witness' Signature Date Time