Penn Psychiatric Center/Collegeville Psychological Center

3774 Ridge Pike
Collegeville, PA 19426
610-489-3333 / FAX: 610-489-9390

601 Gay Street, Suite 6
Phoenixville, PA 19460
610-917-2200 / FAX: 610-917-2360

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CONSENT FOR RELEASE OF INFORMATION- Primary Care Physician Information

Name of Client: ..... DOB:...../...../.....

Address.....

I, ...hereby authorize **Penn Psychiatric Center/Collegeville Psychological Center**

to Release information to: via verbal via fax

to Obtain Information from: via Phone via written

Name (Person, Agency, Medical Practice): _____

Address: .....

Phone: (.....)-..... FAX: (.....)-.....

THIS BOX TO BE FILLED OUT WITH CLINICIAN AT TIME OF APPOINTMENT - Please **check** all the specific Information to be released regarding treatment dates

from: ...../...../..... to: ...../...../.....

- _____ **Psychiatric Evaluation**
- _____ **Psychosocial History**
- _____ **Summary of Treatment to Date**
- _____ **Academic/School Records**
- _____ **Discharge Summary**
- _____ **Other**.....
- _____ **Psychological Evaluation**
- _____ **Medications**
- _____ **Communication and Treatment Plan**
- _____ **Medical History**
- _____ **Lab Reports**
- _____ **Other** .....

Upon signing below, I consent to the disclosure of my protected Mental Health information as indicated above for the specific purpose of Continuity of Care. Information to be released shall be forwarded to the attention of Primary Care Physician and/or Penn Psychiatric Center/Collegeville Psychological Center.

I have been informed that I may revoke this authorization by written or verbal communication. I have also been informed of my right (subject to Section 5100.3-39 of the regulations promulgated under the Mental Health Procedures Act of 1976) to inspect the information to be released. Furthermore, I consent to the disclosure of information relating to my alcohol and/or drug dependency provided that disclosure is limited, (pursuant to the Pennsylvania Drug and Alcohol Abuse Act of 1972) to medical personnel for the purpose of further treatment and government or other officials for the purpose of obtaining benefits.

This consent to release information is effective from: ...../...../..... to:...../...../.....
(not to exceed one year)

_____ **Date of Signature:-**...../...../.....
Signature of Client

_____ **Date of Signature**: ...../...../.....
Signature of Witness (If Patient is physically unable to sign)

_____ **Date of Signature**: ...../...../.....
Signature of Witness

(The Information enclosed is confidential. The law prohibits further copying without written consent of the person to whom it pertains. Redisclosure of this information is strictly prohibited and may be subject to civil liability

NOT AFFILIATED WITH THE UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM OR HOSPITALS Revised 11/22/16