Penn Psychiatric Center

3774 Ridge Pike
Collegeville, PA 19426
Phone: (610) 489-3333
Fax: (610) 489-9390

601 Gay Street
Phoenixville, PA 19460
Phone: (610) 917-2200
Fax: (610) 917-2360

CONSENT FOR RELEASE OF INFORMATION– Emergency Contact/Family Contact

Name of Client: _____ DOB: _____

Address: _____

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

☐ To Release Information to: ☐ To Obtain Information from:

☐ via verbal ☐ via fax/ written

Name: _____Relationship to Client_____

Address: _____

Phone: _____ FAX:_____

Check Personal Health Information to be released for: ☐ All Treatment dates or ☐ Treatment dates from: _____ to: _____

☐ **Psychiatric Evaluation**	☐ **Summary of Treatment to Date**	☐ **Lab Reports**
☐ **Medications**	☐ **Medical History**	☐ **Other:** _____
☐ **Biopsychosocial History**	☐ **Communication and Treatment Plan**	☐ **Other:** _____
☐ **Discharge Summary**	☐ **Academic/School Records**	

Upon signing below, I consent to the disclosure of my protected Mental Health information as indicated above for the specific purpose of EmergencyContact/Family Contact for Continuity of Care. Information to be released shall be forwarded to the attention of Emergency/Family Contact 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 Office Staff

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