Penn Psychiatric Center/Collegeville Psychological Center
3774 Ridge Pike
Collegeville PA 19426
610-489-3333 FAX: 610-489-3393
401 Gay Street Suite 6
Phoenixville PA 19460
610-917-2200 / FAX: 610-917-2360

CONSENT FOR RELEASE OF INFORMATION- General

Name of Client: Client Name DOB: Month/Day/Year

Address: Complete mailing address including City, State, Zip Code

I, Client Name hereby authorize **Penn Psychiatric Center/Collegeville Psychological Center**

☐ to Release information to: ☐ to Obtain Information from:
☐ via verbal ☐ via fax ☐ via Phone ☐ via written

Check all that apply

Name (Person, Agency, Medical Practice): _____ Relationship to Client_____
Address: Info of Person or Entity to/from whom information may be released
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

Ignore that. Fill this ENTIRE box out now.

from: Today's date to: One year from today

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

At least one of these items must be checked

Upon signing below, I consent to the disclosure of my protected Mental Health information as indicated above for the specific purpose of Mental Health Treatment (Reason for Release/Obtain). Information to be released shall be forwarded to the attention of Name of Person or Entity to/from whom information may be realased 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: Today's date *to:* One year from today
(not to exceed one year)

Client must sign
_____
Signature of Client

Date of Signature:- Fill this out too

_____
Signature of Witness (If Patient physically unable to

Date of Signature:

_____
Signature of Witness

Date of Signature:

(The Information disclosed 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