



THE UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE

Center for the Treatment and Study of Anxiety
Department of Psychiatry
University of Pennsylvania

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CONSENT TO RELEASE INFORMATION

I, _____ hereby authorize the University of Pennsylvania Psychiatry Department to release to:

_____ Name and Address of Person or Organization
copies of the Psychiatric and Medical Information from the Medical Records pertaining to my evaluation of _____ (*Specify exact information needed.*) These records are required for the purpose of _____
_____.

I understand that my authorization shall remain valid from the date of my signature beginning on _____ and for 30 days ending _____.

I have been informed that I may revoke this authorization by written or oral request except to the extent that action has been taken in reliance thereon. I have also been informed of my right subject to the Mental Health Procedures Act, 1976 (55Pa Code #5100.34) to inspect the information released and of the confidentiality provisions of Section 8 c of the Pennsylvania Drug and Alcohol Abuse Act 1982, and comply with the Confidentiality of HIV-Related Information Act, 1991 (35 P.S. #7607 c).

I acknowledge that I have read and understand this form and its contents.

Signature of Patient (14 years or older)

Date of Authorization

Signature of Parent or Guardian

Name of Patient 13 years or younger

Relationship to Patient

Patient's Date of Birth

Signature of Staff Obtaining Consent

Patient's Social Security Number