UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM
Department of Psychiatry

Consent for **Release of Information**

I, (print name of patient)_____, AM AWARE THAT THE UNIVERSITY OF PENNSYLVANIA HAS THE LEGAL AUTHORITY TO RELEASE ANY RECORDS AND FILES IT HAS CONCERNING ME WITHOUT PRIOR WRITTEN CONSENT TO THE FOLLOWING PERSONS, AGENCIES, AND ENTITIES:

To any staff member of the University of Pennsylvania or consultant to the University of Pennsylvania involved in my treatment.

To any insurance company (e. g. Magellan, CBH), governmental agency (e.g. Medicare Oversight Agency), or other person who may be paying for my treatment. When information is released for payment purposes, it will be limited to staff names, dates, types, and costs of therapy and services and a short description of the general purpose of each treatment session or services provided.

To the Commonwealth of Pennsylvania, departments and agencies including organizations involved in utilization review which may be involved in certifying or approving the University of Pennsylvania under application statutes.

To the County Administrator so that he/she may fulfill his/her duties under applicable statutes and regulations.

To a Court or Mental Health Review Officer in the course of legal proceedings that are permitted by the Mental Health Procedures Act or in response to a Court Order or Subpoena of Documents.

To all Department of Public Welfare personnel, when they are authorized to review such records under appropriate regulations.

To any appropriate person if there is an emergency medical situation in which information is necessary to prevent the serious risk of bodily harm or death, but only to the extent relevant to any emergency.

To parents or guardians or other appropriate people, if and when necessary to obtain written medical consent.

To any attorney assigned to represent me, should I become involved in a commitment hearing.

I understand that the information provided to the various persons, agencies, and entities above will be limited to those records that are relevant and necessary to the purpose for which the information is requested.

_____ _____

Signature of Patient or Legal Guardian Date Signed

_____ _____

Signature of Witness (**PCWBW staff member**) Date Signed