UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM

Center for the Treatment and Study of Anxiety
Edna B. Foa, Ph.D.
Professor and Director

Consent for Communication of Medical Information Including Mental Health

******THIS IS NOT FOR COPYING YOUR MEDICAL RECORDS******

Name: _____ Date of Birth: _____

The purpose of this disclosure authorization is to improve assessment and treatment planning, share information relevant to my treatment, and when appropriate, coordinate treatment services.

I authorize the Center for the Treatment and Study of Anxiety, Department of Psychiatry

- ☐ **to release information to**:
- ☐ **to obtain information from**:

Name of Provider, Facility, or Other Person

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

Center for the Treatment and Study of Anxiety
Department of Psychiatry
3535 Market St, Suite 600
Philadelphia, PA 19104
Appts 215 746 3327
Fax 215 746 3311

TYPE OF COMMUNICATION MAY BE WRITTEN AND/OR VERBAL FROM THE ONSET OF MY TREATMENT:

- ☐ Communication regarding my medical/psychotherapeutic/psychopharmacological treatment
- ☐ Other information (please specify) _____

AUTHORIZATION is VALID FROM ____/____/____ to ____/____/____ (not to exceed one year).

I understand:

- The purpose of this authorization is to improve assessment and treatment planning, share information relevant to my treatment, and when appropriate, coordinate treatment services.
- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time during the authorization period either verbally or by sending written notification to the Operations Manager,3535 Market Street, 2nd Fl, Philadelphia, PA,19104.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- This release includes mental health related care and substance abuse diagnosis and treatment information.

_____
Printed Name of Patient

_____ _____ _____
Patient's Signature Date Time

_____ _____ _____
Witness' Signature Date Time