Penn Medicine

Department of Psychiatry
The Charles O'Brien Center for Addictions Treatment

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 Charles O'Brien Center

☐ **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)

Penn Behavioral Health
Charles O'Brien Center
3535 Market St, 5rd Floor
Philadelphia, PA 19104
Appts 215 746-5900
Fax 215 746-7350

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

☐ Communication regarding my medical/psychotherapeutic/psychopharmacological treatment
☐ Substance use disorder treatment information to include my name, admission status, prognosis, nature of program, progress, and relapse status for the purpose of receiving payment for services that I have received, and only in cases where payment is in dispute, all of my substance use disorder treatment information
☐ 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, Penn Center for Women's Behavioral Wellness,3535 Market Street, 3rd 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

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

Penn Medicine complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATENCIÓN: Si habla español, servicios gratuitos de asistencia del lenguaje están disponibles para usted. Llame al 1-609-853-7490. 1-609-853-749