UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM
Department of Psychiatry

Informed **Consent to Treatment** Form

At my own discretion I am requesting treatment at the Penn Center for Women's Behavioral Wellness at the University of Pennsylvania. I know that my treatment may consist of psychotherapy or a combination of psychotherapy and pharmacotherapy. I will be educated to the benefits and potential side effects or reactions that may result from any prescribed medication. I am aware that I have the right to request a copy of the Physician Desk Reference for my use. This book contains detailed information about prescription medications, adverse affects, and appropriate warnings. I have the right to ask questions regarding my treatment and expect that my questions will be answered to my full satisfaction. If I do withdraw from treatment, I have the right to have a referral to another practitioner for alternative treatment.

I agree to allow the Penn Center for Women's Behavioral Wellness at the University of Pennsylvania to make this document a permanent part of my patient record.

Finally, I understand and will expect that all papers and documents concerning my treatment at the Penn Center for Women's Behavioral Wellness at the University of Pennsylvania will be kept confidential. No information concerning my treatment can be released without my specific written consent except as required by law or in a situation deemed potentially life-threatening. According to Federal Regulations, licensed providers are mandated to report information that professional judgment would determine constitutes threat or serious harm to self or others, or indicates child or elder abuse or neglect. You have my consent, without reservation, to release any such information about me without further written approval.

_____

Patient's Name (printed)

_____ _____

Signature of Patient or Legal Guardian Date Signed

_____ _____

Signature of Witness (**PCWBW Staff Member**) Date Signed