



To submit a new request for **therapy records** or **psychiatry records** for **care provided at the Center for the Treatment and Study of Anxiety**, please complete the attached authorization code and scan it (or photograph it in high resolution) and email it back to us at Danielle.Wylie@Pennmedicine.upenn.edu. Please follow the instructions below to ensure proper completion of the form:

- Check CPUP/CCA Outpatient Practice: CTSA or COTTAGE (depending on which clinic you were seen in)
- Complete the name/address for who you want the record released to (e.g., yourself, law firm, school, etc.).
- Under Special Records, Select "Yes, Disclose" under Psychiatric Care/Treatment for records to be released
- If you would like the typical set of psychology notes that we keep, select Progress Notes, Clinic Notes, Itemized Billing Record, Other: Psychiatric Evaluation
- Complete the purpose of the requested information and the preferred delivery method

Instructions For Completing The Authorization For Disclosure of Health information

1. Please complete all sections of the Authorization For Disclosure of Health information.
2. The patient or legally authorized representative must sign and date the form.
Generally, only a patient may authorize release of his/her medical information.
Exceptions to the rule are as follows:
 - a. Authorization of minors - If the patient is a minor (under 18 years of age), the authorization must be signed by a parent or legal guardian.
 - b. Emancipated minors - An emancipated minor is a minor under the age of 18, who is or has been married, is or has been pregnant or who is a high school graduate. Emancipated minors can authorize release of their medical information.
 - c. A minor who has been diagnosed with a venereal disease, a substance abuse problem or was treated to determine pregnancy may consent to treatment of that disease or condition and may authorize release of any medical information related to that disease or condition.
 - d. Authorization after death - An authorization must be signed by decedent's estate, or in the absence of an executor, the next of kin responsible for the disposition of the remains may give consent for the release of medical information.
 - e. Authorization of the incompetent patient - If the patient is deemed incompetent, then the patient's legally authorized representative must sign the authorization for release of information.

Penn Medicine reserves the right to request proof of representation.

Please Note

1. Penn Medicine will charge for copying records in accordance with Pennsylvania and New Jersey law, as applicable.
2. Penn Medicine will not send medical information by facsimile unless the information is needed for patient care and delay in the transmission of the information would compromise patient care.
3. Information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by relevant federal and/or state law.
4. Penn Medicine will make reasonable efforts to comply with this request within thirty (30) days for information that is maintained or accessible on site and within sixty (60) days for information that is not maintained on site. If Penn Medicine is unable to comply with this request within the specified time periods, it may extend the applicable deadline for up to thirty (30) days by notifying you in writing.
5. Penn Medicine may deny this request under limited circumstances as provided for under federal law. Penn Medicine will notify you if it denies your request to access or obtain a copy of the requested information. If Penn Medicine denies this request, you may have the right to have a denial of your request reviewed by a licensed health care professional. To request such a review, please contact the Penn Medicine Chief Privacy Officer at the following address:

University of Pennsylvania Health System
Office of Audit, Compliance and Privacy
3819 Chestnut Street, Suite 214
Philadelphia, PA 19104

Penn Medicine

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Label Area

Patient Name (First, Middle, Last)		Date of Birth										
Address		City/State/Zip Code										
Address		Telephone Number										
<p>I am requesting my protected health information (PHI) from Medical Records:</p> <p><input type="checkbox"/> All Penn Medicine Locations</p> <p><input type="checkbox"/> Hospital of the University of Pennsylvania - 3400 Spruce Street, 1st Floor Founders, Philadelphia, PA 19104</p> <p><input type="checkbox"/> Penn Presbyterian Medical Center - 51 N. 39th Street, Myrin Basement, Philadelphia, PA 19104</p> <p><input type="checkbox"/> Pennsylvania Hospital - 8th and Spruce, 1st Floor Preston, Philadelphia, PA 19107</p> <p><input type="checkbox"/> Penn Chester County Hospital - 701 East Marshall Street, West Chester, PA 19380</p> <p><input type="checkbox"/> Penn Home Care & Hospice</p> <p><input type="checkbox"/> CPUP/CCA Outpatient Practice(s) <input type="checkbox"/> Other:</p>												
I request my PHI be released to:												
Name of Person or Institution:		Address										
City:	State:	Zip Code:	Fax (if Healthcare Provider):									
<p>Special Records: I understand that information related to my diagnosis or treatment for AIDS/HIV, psychiatric care and treatment, treatment for drug and alcohol abuse may be released as part of my health information. Please check appropriate box(es) below:</p> <table style="width: 100%; border-collapse: collapse;"><tr><td style="width: 33%;"><input type="checkbox"/> AIDS/HIV Infection</td><td style="width: 33%;"><input type="checkbox"/> Psychiatric Care/Treatment</td><td style="width: 33%;"><input type="checkbox"/> Drug or Alcohol Abuse Treatment</td></tr><tr><td><input type="checkbox"/> Yes, disclose</td><td><input type="checkbox"/> Yes, disclose</td><td><input type="checkbox"/> Yes, disclose</td></tr><tr><td><input type="checkbox"/> No, do not disclose</td><td><input type="checkbox"/> No, do not disclose</td><td><input type="checkbox"/> No, do not disclose</td></tr></table>				<input type="checkbox"/> AIDS/HIV Infection	<input type="checkbox"/> Psychiatric Care/Treatment	<input type="checkbox"/> Drug or Alcohol Abuse Treatment	<input type="checkbox"/> Yes, disclose	<input type="checkbox"/> Yes, disclose	<input type="checkbox"/> Yes, disclose	<input type="checkbox"/> No, do not disclose	<input type="checkbox"/> No, do not disclose	<input type="checkbox"/> No, do not disclose
<input type="checkbox"/> AIDS/HIV Infection	<input type="checkbox"/> Psychiatric Care/Treatment	<input type="checkbox"/> Drug or Alcohol Abuse Treatment										
<input type="checkbox"/> Yes, disclose	<input type="checkbox"/> Yes, disclose	<input type="checkbox"/> Yes, disclose										
<input type="checkbox"/> No, do not disclose	<input type="checkbox"/> No, do not disclose	<input type="checkbox"/> No, do not disclose										
I authorize the following PHI to be released from my medical records:												
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Radiology Images/Reports									
<input type="checkbox"/> Discharge Instructions	<input type="checkbox"/> ER Record	<input type="checkbox"/> EKG/ECG Cardiac Tests	<input type="checkbox"/> Abstract (Significant Documents)									
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Clinic Notes	<input type="checkbox"/> Itemized Billing Record									
<input type="checkbox"/> Consultations	<input type="checkbox"/> Medication Records	<input type="checkbox"/> Radiology Reports										
<input type="checkbox"/> Other Instructions:												
Covering the period(s) of care (list applicable dates of treatment): ___ / ___ / ___ to ___ / ___ / ___												
Purpose of requested information:		Delivery Method:										
<input type="checkbox"/> Legal	<input type="checkbox"/> Insurance	<input type="checkbox"/> US Mail (Paper)	<input type="checkbox"/> Email (not secure) File size limits apply									
<input type="checkbox"/> Personal	<input type="checkbox"/> Continuation of Care	<input type="checkbox"/> CD										
<input type="checkbox"/> Other _____												
<p><i>!!!Important!!!</i> I understand that the CD/disc of images are not encrypted and may be accessible to others if the CD/disc is lost or stolen. I also understand that unencrypted email is not secure and therefore may be intercepted by others. I also understand that email may be misdirected and easily forwarded to unintended recipients. By choosing to receive my health information by CD/disc or via email, I am accepting these risks.</p>												
AUTHORIZATION												
I hereby authorize Penn Medicine to disclose the health information as described above. I understand that my authorization will automatically expire one hundred eighty (180) days after the date of signature on this form. I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by relevant federal and/or state law. If I have requested to receive health information electronically, I acknowledge and accept the risks described above concerning unencrypted electronic formats. My refusal to sign this authorization will not affect my ability to receive treatment. By signing this form, I understand that I am authorizing Penn Medicine to release information as described above.												
Signature of Patient or Personal Representative		Print Name	Date Time									
Relationship of Personal Representative to Patient		Date	Time									
If Authorization is signed by someone other than the patient, please state reason:												
If psychiatric care information is being released as authorized above, signature of hospital representative validating authorization required.												
Signature of Hospital Representative		Print Name	Date Time									
Signature of Second Witness for Verbal Consent		Print Name	Date Time									
This information has been disclosed to you from records whose confidentiality is protected by State statute. State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains.												

PLEASE READ THE FOLLOWING INSTRUCTIONS ON REVERSE

