

This information has been disclosed to you from records protected by Federal confidentiality (42 CFR Part 2) and PA law. The Federal and State law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Drexel University College of Medicine
Department of Psychiatry

CONSENT TO RELEASE/OBTAIN PATIENT INFORMATION

3200 Henry Avenue, Philadelphia, PA 19129
TEL 215.842-4200 FAX 215.843.3200

I hereby authorize the Drexel University College of Medicine, Department of Psychiatry, to release/obtain the following information from the health records of:

PATIENT'S NAME: _____ DATE OF BIRTH: _____ AGE: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
TELEPHONE #(_____) _____ SOCIAL SECURITY # _____

The purpose and need for such disclosure:

____ Continuation of Care ____ Insurance/Billing ____ Disability Determination ____ Legal Follow-Up ____ Vocational Rehabilitation
____ School ____ Social Service Referral ____ Other: _____

Information to be released/obtained:

Types of Service (mark appropriate line):

- Inpatient Record _____
- Emergency Room _____
- Short Procedure _____
- D/C Summary _____
- Outpatient Record _____
- Immunization Record _____
- Lab Reports _____
- Radiology Reports _____
- Psych Evaluation _____
- Treatment Plan _____

Types of Reports (mark appropriate line):

- Pathology Report _____
- Operative Report _____
- Consultation _____
- Abstract of Record _____
- History and Physical _____
- Other (pls. Specify) _____

INFORMATION TO BE RELEASED TO/OBTAINED FROM:

Name: _____ Address: _____
Telephone #(_____) _____ City: _____ State: _____ Zip _____

For the purpose of: _____

INFORMATION RELEASED/OBTAINED VIA: _____ Telephone _____ US Mail _____ Other _____

SPECIAL AUTHORIZATION FOR RELEASE OF MENTAL HEALTH/REHABILITATION/ALCOHOL-DRUG ABUSE AND AIDS/HIV TESTING CONTAINED IN PATIENT'S MEDICAL RECORD.

I UNDERSTAND THE NATURE OF THE CONSENT AND THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE 6 (SIX) MONTHS AFTER IT IS SIGNED. I UNDERSTAND THIS CONSENT IS SUBJECT TO REVOCATION, IN WRITING, AT ANY TIME EXCEPT IF DREXEL UNIVERSITY COLLEGE OF MEDICINE, DEPT. OF PSYCHIATRY, HAS ALREADY TAKEN ACTION FOR THE DISCLOSURE. IF THE PATIENT IS PHYSICALLY UNABLE TO SIGN, A MINOR, OR LEGALLY INCOMPETENT, THE PARENT, OR LEGALLY AUTHORIZED REPRESENTATIVE MUST SIGN BELOW. TWO WITNESS SIGNATURES REQUIRED FOR VERBAL CONSENT ONLY IF PATIENT IS 14 YEARS OLD OR GREATER AND IS DEEMED MENTALLY COMPETENT PATIENT MAY SIGN.

IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL EXPIRE ON THE _____ DAY OF _____, 20____.

Date: _____ Signed: _____
Patient/Parent or Guardian

Date: _____ Signed: _____
Witness

Date: _____ Signed: _____
Second Witness (if necessary)

If not patient, please check appropriate space: _____ Parent _____ Guardian _____ Executor of Estate _____ Witness(verbal consent only)

We will not release any information about the patient to anyone without the patient's (or their guardian's) permission.

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