Main Line Health | BEHAVIORAL HEALTH

□ Main Line Affiliates – Exton 479 Thomas Jones Way, Suite 800 Exton, PA 19341	□ Main Line Affiliates – Drexel Hill 401 Pilgrim Lane, Suite 100 Drexel Hill, PA 19026	□ Main Line Affiliates – Newtown Square 3855 West Chester Pike, Suite 160 Newtown Square, PA 19073

Authorization for Disclosure of Health Information

I hereby authorize Main Line Affiliates to: □ release / □ receive medical information from the records of:

Patient Name: _____ DOB: _____

Covering the period(s) of care (list the dates of treatment): _____

Information to be disclosed: (check all applicable items to be released; for a complete chart copy, place a check in all boxes)

☒	Discharge Summary	☒	Progress Notes	☒	Patient Progress
☒	Psychiatric Evaluation	☒	Medication Records	☒	History and Physical
☒	Treatment Plan	☒	Laboratory Test Results		
☒	Other (please specify)	Psychiatric Notes			

I understand that this will include information relating to my Psychiatric Care and Treatment

Purpose of Request: ☐ Family Involvement ☐ Continuity of Care ☐ Emergency Contact ☐ Other _____

This information will be received by / released from: _____

Address: _____

City / State / Zip Code: _____ **Phone # (for questions):** _____

I understand that this authorization may be revoked at any time, except to the extent that action has already been taken to comply with this request. This authorization will automatically expire in 90 days unless otherwise revoked or indicated to expire on _____ (date not to exceed 90 days). In accordance with PA state law, I understand that there is a fee for obtaining copies of records, except for copies mailed directly to a health care facility or physician and I agree to pay such charges.

_____ _____ _____
(Signature of patient or legal representative) (This Date is the day the authorization is effective) (Relationship to Patient)

_____ _____
(Signature of Witness) (Signature Date)

Release of Drug and Alcohol Information

This authorizes information subsequent to 42CFR Part 2 to be released consistent with the provisions that prohibit making any further disclosure of it without consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

_____ _____ _____ _____
(Signature of patient) (Date) (Witness) (Date)

Verbal Release of Mental Health Information

Verbal Consent to release mental health information is acceptable if the patient is physically unable to provide a signature and verbal consent is witnesses by two persons.

We, the undersigned, certify that _____ was physically unable to provide a signature and, he / she understood the nature of this release and freely gave his / her consent.

_____ _____ _____ _____
(Witness) (Date) (Witness) (Date)