Main Line Health® | BEHAVIORAL HEALTH

Emergency Contact Release Form

I, _____, HEREBY FREELY AUTHORIZE
(Name)

MAIN LINE BEHAVIORAL HEALTH AFFILIATES
WOMEN'S EMOTIONAL WELLNESS CENTER
(Person or Facility Releasing Information)

TO RELEASE TO:
Emergency Contact:

Name: _____ Phone #: _____

Relation to Above: _____

- My presence in treatment __**X**__
- My projected prognosis _____
- The nature of the program __**X**__
- Diagnosis Code _____

The Purpose of this information is for/to one or more of the following:

- Continuity of Care _____
- Assist with legal issues _____
- Update medical records _____
- Settle Insurance claim _____
- Authorization of treatment _____
- For Emergency Situations __**X**__

The method of releasing this information is:

- Telephone Contact __**X**__
- Fax __**X**__
- In Person __**X**__
- E-Mail ___**X**___

THIS AUTHORIZATION IS SUBJECT TO VERBAL OR WRITTEN REVOCATION AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON. THIS AUTHORIZATION WILL EXPIRE 360 DAYS AFTER THE DATE OF MY SIGNATURE OR ON _____. THIS RELEASE IS VALID FOR THE FULL 360 DAYS, EVEN IF TREATMENT IS COMPLETED AND/OR TERMINATED. THIS RELEASE OF INFORMATION IS LIMITED TO THE PERSON OR ORGANIZATION NAMED ABOVE AND WILL NOT BE USED FOR ANY OTHER PURPOSE THAN THAT STATED.

_____ _____
Witness's Signature Date Patient's Signature Date

CIRCLE ONE: PATIENT DOES / DOES NOT WISH COPY OF THIS CONSENT

"THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42CRF, PART 2) PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN 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."