Main Line Health
Behavioral Health

□ American Day Treatment Center – Exton
479 Thomas Jones Way, Suite 800
Exton, PA 19341

□ American Day Treatment Center – Broomall
600 Abbott Drive
Broomall, PA 19008

Authorization for Disclosure of Health Information

I hereby authorize American Day Treatment Center to: □ release / □ receive medical information from the records of:

Patient Name: _____ DOB: _____

Covering the period(s) of care at ADTC (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	☐	Psychological Evaluation	☐	Evaluation Report (School related)
☐	Psychiatric Evaluation	☐	Medication Records	☐	Educational Summary
☐	History and Physical	☐	Consultations	☐	Doctor's Orders
☐	Treatment Plan	☐	Nursing Assessment	☐	Laboratory Test Results

☐ Patient Progress (Verbal)
☐ Medical Information (please specify) _____
☐ Other (please specify)_____

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:_____
(Name of Person or Institution)

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. 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)	(Date – Release becomes effective)	(Signature of Witness)
_____	_____	_____
(Date of Signature)	(Date- Release expires)	(Date of Signature)

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)