PENN
BEHAVIORAL HEALTH
CORPORATE SERVICES

PENN Behavioral Health

Authorization to Release Information

I, _____ authorize _____ and PENN Behavioral Health
(Member Name) (Provider Name)
to release an evaluation summary and treatment plan updates to my **Primary Care Physician (PCP)** to encourage the best possible communication among the professionals who are involved in my care.

❑ No, I do not authorize PENN Behavioral Health to release these documents to my PCP.

I understand that this consent is valid for a period from _____ to _____.

I understand that I may revoke this authorization at any time by sending a written notice to PENN Behavioral Health Services, Department of Medical Records, 3535 Market Street, 4th Floor, Philadelphia, PA 19104.

_____ _____
Signature of member, parent or guardian **Date**

_____ _____
Signature of witness **Date**

Important Member Information

Emergency Care:
PENN Behavioral Health Participating Providers are available to help you in case of an emergency. Ask your provider now what their procedures are to reach them in case of an emergency and write them down with all important phone numbers here:

_____

_____

PENN Behavioral Health has additional 24-hour emergency services available if necessary by calling: **1-888-321-4433**

My co-payment schedule for outpatient services is: ❑ Visits 1-2 = free, Visits 3-10 = $10.00, Visits 11-20 = $25.00, or
Visits 1-20 = ❑ $5.00 ❑ $10.00 ❑ $15.00 ❑ $20.00 ❑ $25.00 ❑ Other: _____

Visits Beyond Your Benefit Allowance:
If you and your provider agree that you need to continue outpatient treatment beyond your benefit cycle, your provider may contact the PENN Behavioral Health Care Manager to request certification. In the absence of this option, you may make individualized arrangements with your provider for out-of-plan care. A mutually signed, written copy of this agreement must be forwarded to PENN Behavioral Health and must indicate that both you and your provider agree to hold PENN Behavioral Health and your insurer harmless from any financial obligation arising out of this continuing treatment arrangement.

Missed or Canceled Visits:
Your provider reserves an extended period of time for your appointment so you may be required to pay a fee of $ _____ for any appointment that is missed or canceled with less than 24 hours notice. This charge would be due at the beginning of your next visit. You must call your provider to report any cancellations. Please call (provider phone #) _____ at least 24 hours before your scheduled appointment to avoid this charge.

Release of Information:
Please be informed that your provider is required to forward to PENN Behavioral Health information necessary for the administration and provision of your healthcare benefits.

I have read and understand the information contained above as well as the member rights and responsibilities:
I have ❑ received a copy of this form and the member rights and responsibilities for my personal records, or ❑ declined a copy

_____ _____
Signature of member, parent or guardian **Date**

(Original to Chart; Copy to Member)

PNF-307 AEL 8/2002

© 2008, PENN Behavioral Health