MOSAIC MIND PSYCHIATRY
Consent for Release of Information

I AM AWARE THAT MOSAIC MIND PSYCHIATRY HAS THE LEGAL AUTHORITY TO RELEASE ANY RECORDS AND FILES IT HAS CONCERNING ME WITHOUT PRIOR WRITTEN CONSENT TO THE FOLLOWING PERSONS, AGENCIES, AND ENTITIES:

1. **Insurance Companies or Payers** – To any insurance company (e.g., UHC, Cigna, BCBS), governmental agency (e.g., Medicare Oversight Agency), or other party responsible for paying for my treatment. Information released for payment purposes will be limited to staff names, dates, types, and costs of therapy or services, along with a brief description of the general purpose of each session or service provided.

2. **Commonwealth of Pennsylvania Agencies** – To the Commonwealth of Pennsylvania, its departments, agencies, and any organizations involved in utilization review, for purposes related to certifying or approving Mosaic Mind Psychiatry applications under applicable statutes.

3. **County Administrator** – To the County Administrator, as necessary to fulfill statutory or regulatory duties.

4. **Courts and Legal Authorities** – To a Court or Mental Health Review Officer during legal proceedings authorized under the Mental Health Procedures Act, or in response to a Court Order or Subpoena.

5. **Department of Public Welfare Personnel** – To personnel of the Department of Public Welfare, when authorized to review such records under applicable regulations.

6. **Emergency Situations** – To any appropriate person in a medical emergency, when disclosure is necessary to prevent serious bodily harm or death, and only to the extent relevant to the emergency.

7. **Parents, Guardians, or Authorized Individuals** – To parents, guardians, or other appropriate individuals when necessary to obtain written medical consent.

8. **Legal Representation** – To any attorney assigned to represent me in a commitment hearing.

I understand that any information disclosed under this authorization will be limited to records relevant and necessary for the purpose for which it is requested.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: _____

DATE SIGNED: _____