

**Samaritan Counseling Center**  
1803 Oregon Pike • Lancaster, PA 17601 • 717-560-9969  
**AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION**  
**FROM/TO PRIMARY CARE PHYSICIAN**

Please read and complete all items

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I authorize the use/disclosure of health information about me as described below:

**OBTAIN** from or **RELEASE** to what organization:

Organization Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**Complete this section with your Clinician at the time of your appointment.**

This authorization is for the purpose of Coordination of Care with Primary Care Physician.

- |  |   |
|--|---|
| <input type="checkbox"/> Initiation of Treatment Letter  | <input type="checkbox"/> Psychological Evaluation |
| <input type="checkbox"/> Summary of Treatment to Date    | <input type="checkbox"/> Medications              |
| <input type="checkbox"/> Termination of Treatment Letter | <input type="checkbox"/> Medical History          |
| <input type="checkbox"/> Discharge Summary               | <input type="checkbox"/> Lab Reports              |
| <input type="checkbox"/> Treatment Plan                  | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> Verbal and Phone Communication  |   |

I do NOT wish Samaritan Counseling Center to disclose my Health Information to my Primary Care Physician at this time.

I understand that the information in my health record will include information about behavioral or mental health services. It may also include information about treatment of alcohol or drug abuse or information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).

State and Federal Law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained:

Alcohol, Drug or Substance Abuse Records	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HIV Testing and Results	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under the terms of this authorization.

I understand that I may revoke this authorization in writing at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires at the termination of my treatment at Samaritan Counseling Center.

Name of Patient: \_\_\_\_\_

Signature of Patient or Personal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

If Personal Representative, Print Name: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

If the patient is unable to consent or is a minor, complete the following. Patient is:

- Minor       Incompetent       Disabled

Legal Authority:

- Custodial Parent     Legal Guardian     Power of Attorney for Healthcare     Authorized Legal Representative

If you have any questions, please call 717-560-9969.