Samaritan Counseling Center

1803 Oregon Pike ● Lancaster, PA 17601 ● 717-560-9969

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Please read and complete all items

Patient Name:_____

Date of Birth:_____ SSN:_____ Phone Number:_____

Address:_____ City, State, Zip:_____

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 Record OR
□ Referral/Treatment Summary OR
□ Billing Information Only OR
□ Other (please specify):_____

For the purpose of:

□ Change of therapist □ Personal □ Insurance Eligibility/Benefits □ Medical care
□ Legal Investigation/Action □ Billing □ Other (please specify):_____

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	□ Yes	□ No
HIV Testing and Results	□ Yes	□ No

I understand that if the use/disclosure of these records is for my own use, I will receive either a copy or a summary of my health information within 30 days of my request and that I may be charged a reasonable, cost-based fee.

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 on_____ or one year after the date of execution, whichever comes first.

Name of Patient:_____

Signature of Patient or Personal Representative:_____ Date:_____

If Personal Representative, Print Name:_____

Signature of Witness:_____ Date:_____

Verbal Authorization

The undersigned verify that verbal authorization for release of the above confidential information has been given. The client or parent/guardian was fully informed of the information contained herein and understood its nature and the intended use of the released information

_____ _____

Witness Signature Date Witness Signature Date

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

□ Minor □ Incompetent □ Disabled □ Deceased

Legal Authority:

□ Custodial Parent □ Legal Guardian □ Executor of Estate of Deceased □ Power of Attorney for Healthcare
□ Authorized Legal Representative

If the patient is physically unable to provide a signature and has records that are being released pursuant to the Pennsylvania Mental Health Procedures Act Regulations, complete the following. If not, please skip this section.

Responsible Person's Name:_____

Responsible Person's Signature:_____ Date:_____

Responsible Person's Name:_____

Responsible Person's Signature:_____ Date:_____

Please mail, fax or bring this form to:

Samaritan Counseling Center
Attn: Medical Records
1803 Oregon Pike
Lancaster, PA 17601
717-560-9969
Fax 717-560-9553

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