# 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

Client 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.

- □ Initiation of Treatment Letter
- □ Summary of Treatment to Date
- □ Termination of Treatment Letter
- □ Discharge Summary
- □ Treatment Plan
- □ Verbal and Phone Communication
- □ Psychological Evaluation
- □ Medications
- □ Medical History
- □ Lab Reports
- □ Other_____

☐ 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 | □ Yes | □ No |
| HIV Testing and Results | □ Yes | □ 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 on_____ or one year after the date of execution, whichever comes first.

_____

Client signature (or parent/guardian signature if client is a minor or unable to consent) Date

If Parent/Guardian, Print Name:_____

_____

***Signature of minor client, if minor is 14 years or older** 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.