SAMARITAN COUNSELING CENTER

1803 Oregon Pike Lancaster, PA 17601 717-560-9969 FAX 717-560-9553

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

By my signature below, I give my consent to the Samaritan Counseling Center to use and disclose, for the purpose of carrying out treatment, payment, and/or health care operations, protected health information in reference to

Client Name _____ Date of Birth _____ Social Security Number _____

Relationship to Client _____

I have had the opportunity to review the **Notice of Privacy Practices** of the Samaritan Counseling Center. I understand that the terms of this Notice may change from time to time, in which case I will be notified of such changes, either verbally or in writing, and, upon my request will be provided the opportunity to review the new Notice.

I understand that I have the right to request that the Samaritan Counseling Center restrict the use or disclosure of protected health information for carrying out treatment, payment and/or health care operations. I also understand that the Samaritan Counseling Center is not required to agree to any restriction; however, if the requested restrictions are agreed to by the Samaritan Counseling Center, those restrictions are binding.

In addition, I understand that the Samaritan Counseling Center may make treatment conditional on my signing this Consent.

Finally, I understand that I have the right to revoke this Consent, in writing, at any time, except to the extent that the Samaritan Counseling Center has acted in reliance hereon.

Signature _____ Date _____

SCC Representative _____ Date _____
My signature above verifies that the Client received adequate explanation to make an informed decision

Restrictions: _____

Comments: _____ Client Initials _____