Samaritan Counseling Centers, Inc.

RELEASE OF INFORMATION FOR INSURANCE PROVIDERS

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

I voluntarily consent to authorize Samaritan Counseling Centers, Inc. to use or disclose my health information during the term of this authorization. I have been informed of information that will be released, the purpose and intended use of the released information, and any known consequences of this release. The information to be released is private and subsequent use and release of this information should be treated as such.

INFORMATION TO BE DISCLOSED: Routine and recurring events, information related to service provision including treatment plans, progress on goals and objectives, financial information, protected health information including medications and treatments, information related to eligibility for services through insurance companies, and for funding.

FOR THE FOLLOWING PURPOSE: I understand all medical/mental health information is confidential under certain state and federal laws. Such information may not be released without my consent. Many insurance carriers require medical information to be submitted with claims to evaluate the necessity for treatment and/or services. Please provide your written consent to release related information when required to your insurance company(s) and/or your healthcare team.

I do hereby authorize Samaritan Counseling Centers, Inc. to acquire and/or release any information required for the purposes of healthcare management and/or for processing all medical insurance claims on my behalf. I understand that upon acceptance of services from Samaritan Counseling Centers, Inc. I assume responsibility for a deductible, copay or other balance not covered by my insurance carrier. I authorize Samaritan Counseling Centers, Inc. to submit claims to my insurance company on my behalf and my insurance company to pay benefits directly to Samaritan Counseling Centers, Inc. Should any insurance payment be made directly to the insured for monies due on this account, I agree to immediately pay over these funds to Samaritan Counseling Centers, Inc. I will be informed of my insurance coverage and estimated out-of-pocket expense.

My signature acknowledges that I have read and understand this statement describing the nature of this program's services and limitations of service. I have received a copy of the notice of privacy practices and all of my questions regarding this information have been answered.

_____		_____
Client Name	Date	Signature of Client
_____		_____
Guardian Name	Date	Signature of Guardian
_____		_____
Witness Name	Date	Signature of Witness