

Samaritan Counseling Center

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

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Please read and complete all items

Client Name: _____

Date of Birth: _____ State ID: _____ 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.

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 client is a minor or is unable to consent, complete the following.

- Minor Incompetent Disabled

Legal Authority:

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

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 client 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.

Samaritan Center Nondiscrimination Statement: Discrimination is Against the Law

Samaritan Center complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Samaritan Center does not exclude people or treat them differently because of their ethnicity, color, national origin, age, disability, or sex.

Samaritan Center:

- Provides free assistance and services to people with disabilities to communicate effectively with us, such as:
 - Trained sign language interpreters.
 - Information written in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose first language is not English, such as:
 - Trained interpreters.
 - Information written in other languages.

If you need these services, please contact Steven Schedler, LCSW.

If you believe that Samaritan Center failed to provide these services to you or otherwise discriminated against you on the basis of ethnicity, color, national origin, age, disability, or sex, you may file a complaint with the following person: Steven Schedler, Executive Director, Samaritan Center, 1803 Oregon Pike, Lancaster, PA 17601, 717-560-9969, Fax 717-560-9553 or info.scc@samaritanlancaster.org. You can file the grievance in person or by mail, fax, or email. If you need help doing so, Steven Schedler is here to help.

You may also file a civil rights complaint with the Office for Civil Rights of the U.S. Department of Health and Human Services electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail at the following address or by telephone at the numbers listed below:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

You can get the claim forms on the <http://www.hhs.gov/ocr/office/file/index.html> website.

This information is also posted on our website and in our waiting rooms. You may also ask for a copy of this form.

Signature _____

Date: _____

Client Name: _____ State ID Number: _____

PerformCare Member Rights and Responsibilities

1. **Be treated with dignity and privacy.** Each member has the right to be treated with respect, recognizing their dignity and need for privacy, by PerformCare staff and network providers.
2. **Receive information.** Each member has the right to get information that they can easily locate and understand about PerformCare, its services, and the providers who treat them when they need it.
3. **Choose their provider.** Each member has the right to pick any PerformCare network providers that they want to treat them. Members may change providers if they are unhappy.
4. **Receive emergency services.** Each member has the right to get emergency services when they need them from any provider without PerformCare's approval.
5. **Receive medical and treatment information.** Each member has the right to get information that members can easily understand from their providers and to be able to talk to providers about their treatment options, without any interference from PerformCare.
6. **Make decisions about their treatment.** Each member has the right to make decisions about their treatment. If a member cannot make treatment decisions by themselves, members have the right to have someone else help them make decisions or to make decisions for them. Members may refuse treatment or services unless they are required to get involuntary treatment under the Mental Health Procedures Act.
7. **Communicate with providers in confidence.** Each member has the right to talk with providers in confidence and to have their information and records kept confidential.
8. **Access their medical records.** Each member has the right to see and get a copy of their medical records and to ask for changes or corrections to their records.
9. **Receive a second opinion.** Each member has the right to ask for a second opinion.
10. **File grievances.** Each member has the right to file a grievance if they disagree with PerformCare's decision that a service is not medically necessary for them.
11. **Voice complaints.** Each member has the right to file a complaint if they are unhappy about the care or treatment they have received.
12. **Request a DHS fair hearing.** Each member has the right to ask for a Department of Human Services fair hearing.
13. **Be free from restraint or seclusion.** Each member has the right to be free from any form of restraint or seclusion used to force members to do something, to discipline them, to make it easier for the provider, or to punish them.
14. **Receive information on all available services.** Each member has the right to get information about services that PerformCare or a provider does not cover because of moral or religious objections and about how to get those services.
15. **Exercise their rights freely.** Each member is free to exercise member rights without it negatively affecting the way the Department of Human Services, PerformCare, or network providers treat them.

In addition, members of PerformCare also have the following rights and responsibilities:

1. Provide, to the extent that they can, information needed by their providers.
2. Tell their provider the medicines they are taking. Include over-the-counter medicines, vitamins, and natural remedies.
3. Be involved in decisions about their health care and treatment.
4. Work with their providers to create and carry out their treatment plans.
5. Tell their provider what they want and need.
6. Take their medications as prescribed and tell their provider if there is a problem.
7. Keep their appointments.
8. Learn about PerformCare coverage, including all covered and non-covered benefits and limits.
9. Use only network providers unless PerformCare approves an out-of-network provider.
10. Respect other patients, provider staff, and provider workers.
11. Report fraud and abuse to the Department of Human Services Fraud and Abuse Reporting Hotline.

Second opinion

A second opinion is advice or a recommendation from a second expert to make sure the advice or recommendation from the first expert is correct. All PerformCare members have a right to request a second opinion. PerformCare will provide for a second opinion from an appropriate behavioral health care professional within the network or, if not available, arrange for the member to get one outside the network at no cost to the member.

Client Signature: _____ Date: _____

Client Name: _____ State ID Number: _____

PerformCare - Assurance of Freedom of Choice Form

Per Medical Assistance Bulletin 01-00-16, 29-00-05, 33-00-04, 41-00-03, 48-00-02, 49-00-06, 50-00-04

ISSUE DATE: December 29, 2000, EFFECTIVE DATE: December 29, 2000

www.dhs.pa.gov/docs/Publications/Documents/FORMS%20AND%20PUBS%20OMAP/d_004910.pdf

Federal and state regulations drive the provider's responsibilities regarding Medical Assistance (MA) recipients' freedom of choice when selecting providers and services. The Social Security Act, § 1902(a)(23), requires MA programs to provide any individual eligible for MA the ability to secure services from any institution, agency or practitioner qualified to perform the services. This freedom of choice provision allows MA recipients the same opportunities to choose from among available providers of covered health care as are normally offered to the general public. For individuals enrolled in mandatory managed care (MC) programs, the freedom of choice provision is limited to providers enrolled in the MC network. In addition, 55 PA Code, § 1101.51(a), addresses the recipient's freedom of choice of providers. It states, "A recipient may obtain services from any person or organization that is approved by the Department to provide them and enrolled in the MC network. The provider must not make any direct or indirect referral arrangements between practitioners and other providers of medical services or supplies but may recommend the service of another provider or practitioner.

All members must have the freedom to choose from among the types of medically necessary services compensable through the MA program and contracted with the network. Providers must comply with all federal and state regulations regarding an MA recipient's freedom of choice and should in no way attempt to alter or to influence the recipient's decision and choices.

This form verifies that I have been informed and understand that I have a choice of providers and services available to me through the PerformCare network. If I wish, alternate providers or services will be made available to me through PerformCare Member Services department or the PerformCare Preferred Provider forms. PerformCare Member Services can be reached at the following phone numbers:

Franklin/Fulton: 1-866-773-7917

Capital Region — Cumberland, Dauphin, Lebanon, Lancaster, and Perry: 1-888-722-8646

I am also aware that my provider will discuss with me all treatment options and what the treatment options involve, including advantages and/or disadvantages of each type of treatment.

My family and significant others will be included in treatment if I wish them to be.

Client Signature: _____

Date: _____

Client Name: _____

State ID Number: _____