SAMARITAN counseling center

Release of Appointment Times and Billing Information

Client Name (printed) _____ **Client Date of Birth** _____

AUTHORIZATION TO RELEASE APPOINTMENT TIMES AND BILLING INFORMATION
PLEASE REVIEW CAREFULLY

You have the right to request restriction of your protected appointment time and billing information at any time.

You may request that we communicate your appointment times and billing information in person or over the telephone to family member, relatives, or friends. If you request this right, we are required to have a completed authorization on file ***prior*** to releasing your information. If you wish for someone to have access to your appointment times and billing information, please complete the authorization below.

I AUTHORIZE THE INDIVIDUALS LISTED BELOW ACCESS TO MY APPOINTMENT TIMES AND BILLING INFORMATION:

Name (printed) _____ **Relationship** _____ **Phone Number** _____

Name (printed) _____ **Relationship** _____ **Phone Number** _____

Name (printed) _____ **Relationship** _____ **Phone Number** _____

You may revoke or change this authorization at any time with written notice.

I have received the Samaritan Family Health & Counseling Center's Notice of Privacy Practices and understand that my appointment times and billing information may be used by the Practice as described in the notice.

Client Signature _____ **Date** _____

We are here to help.