NEWTON SQUARE COUNSELING COLLABORATIVE
338 Highland Street
Worcester, MA 01602

CONSENT TO DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Patient Name ____

Home Address ____

Best Contact # ______________________________ Date of Birth ____________________

ACKNOWLEDGEMENT OF RECEIPT OF NEWTON SQUARE COUNSELING COLLABORATIVE (NSCC) NOTICE OF PRIVACY PRACTICES.

By my signature below, I hereby acknowledge that I have read and/or received a copy of Newton Square Counseling Collaborative Notice of Privacy Practices.

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION

By my signature below, I authorize the Newton Square Counseling Collaborative to disclose my medical information so that Newton Square Counseling Collaborative may treat me, seek payment from third parties for treatment (e.g., health insurance) and generally carry on health care operations (e.g., quality assurance).

Patient Signature ____________________________________ Date ________________

Parent/Guardian ____________________________________ Date _______________

2022