Desert Counseling & Recovery Services PLLC

Consent to use and disclose your Health Information

This form authorizes Desert Counseling & Recovery Services to disclose Protected Health Information (PHI) regarding _____.
Client's name.

Protected Health Information (PHI) is defined as any information, whether oral or recorded in any form or medium that is created or received by a health care provider that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. When you meet with a counselor from Desert Counseling, they will be collecting PHI for the purpose of determining which treatment options are best recommended for you. In addition, we use this information to coordinate your care with other professionals who are involved with your care, including insurance companies or alternative payment sources.

By signing below, you agree to let us share your PHI to others such as your insurance company as outlined on the Notice of Privacy Practices. Please make sure to read this notice before signing this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

If you are concerned about some of your information, you have the right to ask us not to share some of your information for treatment, payment, or administrative purposes and will need to tell us what you want in writing. We will try to accommodate your requests; however, we are not required to agree to these limitations, but if we do agree, we will honor our agreement unless we are unable to by law.

After you have signed this request, you can revoke your consent in writing. We will comply with your request from that point forward but will be unable to change or revoke the information that has already been shared. Please be aware that if you revoke your consent, we will be unable to continue providing treatment or services to you.

_____
Signature of client or personal representative Date

_____
Relationship to client/Description of personal representative's authority

_____
Signature of authorized representative of this practice Date_____

_____ I HAVE BEEN GIVEN A COPY OF THE NPP
Client initials