Mountainview Clinical Psychology, PLLC

Welcome To Mountainview Clinical Psychology, PLLC, a private practice Neuropsychology speciality clinic. Please complete the attached paperwork and bring with you to your appointment. You may also email your paperwork to Dr. Husk at drhusk@mountainviewclinical.com.

If you have any change of insurance prior to your appointment, please contact the scheduling/billing line at 623-414-3279 to report your current insurance so that we may verify benefits and obtain any necessary authorization your insurance may require.

Our address is:
14300 N. Northsight Blvd. Suite 215
Scottsdale, AZ 85260

We look forward to meeting you!

Sincerely,

Kristi L. Husk, Psy.D., ABN, CBIS

Board-Certified Clinical Neuropsychologist
Diplomate of the American Board of Neuropsychology
Certified Brain Injury Specialist
AZ Lic. PSY-003959

Enclosures: *New Patient Packet*

PATIENT INFORMATION

Name (First, Middle, Last)	Age	Date of Birth (Required)

Address	City	State	Zip Code

Home Phone	Cell Phone	

Email Address

Emergency Contact
Name: Relationship: Phone Number(s):

Relationship Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

Primary Language(s): ☐ English ☐ Spanish ☐ Other:
First language learned: ☐ English ☐ Spanish ☐ Other:

Gender
☐ Male ☐ Female
☐ Other: _____

Ethnic Background: ☐ Hispanic ☐ Caucasian ☐ African American
☐ Native American ☐ Asian ☐ Other:

PERSON COMPLETING PACKET (IF DIFFERENT THAN ABOVE)

Name (First, Middle, Last)	Relationship to patient	

Address	City	State	Zip Code

Home Phone	Cell Phone	

Years you have known the patient	Your Age	Today's Date:

How often do you see the patient?
☐ Every day ☐ 2 – 3 days per week ☐ 4 – 6 days per week
☐ Once every 2 weeks ☐ Once per month ☐ Less than once per month

How many hours a week do you spend with him/her?

ADDITIONAL CONTACT INFORMATION

Email address: Can we send you e-mail messages? ☐ Yes ☐ No
**All email messages will come encrypted to protect confidential patient information*

Your preferred method of contact? ☐ Home ☐ Cell Phone
Who should be the primary contact person: ☐ Email

Name (First, Middle, Last)	Relationship to patient

Which is the best method to contact the above-named person?
☐ Home: ☐ Cell: ☐ Email:

Can we leave a message with the primary contact?

☐ YES, best method to leave a message: ☐ Home ☐ Cell Phone ☐ Email

☐ NO, don't leave a message please

POWER OF ATTORNEY

Does the patient have a durable Health Care Power of Attorney? ☐ Yes ☐ No

If yes, who is so named?

Does the patient have a durable Mental Health Power of Attorney? ☐ Yes ☐ No

If yes, who is so named?

*IF YES TO EITHER OF THE TWO PREVIOUS QUESTIONS, **PLEASE BRING A COPY** OF THE SUPPORTING DOCUMENTS TO THE INITIAL VISIT.*

GENERAL INFORMATION

Has the patient had a consultation or work up forcurrent symptoms? ☐Yes ☐No

If yes, please provide his/her contact information:

Physician Name:	Phone Number
How long has the patient been seeing this physician?	Fax Number

Does the patient have a primary care physician? ☐Yes ☐No

If yes, please provide his/her contact information:

Physician Name:	Phone Number
How long has the patient been seeing this physician?	Fax Number

Neuropsychological Evaluation History

Has the patient undergone a prior cognitive or Neuropsychological evaluation?	If so, when and where:
Please provide a copy of the prior evaluation if it was not performed at Mountainview Clinical Psychology or sign a release to provide authorization to request this.	

Note: Neurological records (your referring physician) are typically sent to Dr. Husk with your referral	

HEALTH INSURANCE INFORMATION

PLEASE COMPLETE THIS SECTION IN ITS ENTIRETY.

PRIMARY INSURANCE	
Insurance Name	Member ID#
Insurance Claims Address	Group #
Policy Holder Name	
Relationship to policy holder: ☐ Self ☐ Dependent ☐ Spouse/Partner (Member ID#:_____)	

PRIMARY INSURANCE PHONE (EACH CAN BE FOUND ON INSURANCE CARD)
Member's insurance toll free phone number:
Insurance notification/provider's toll-free phone:

SECONDARY INSURANCE	
Insurance Name	Member ID#
Insurance Claims Address	Group #
Policy Holder Name	
Relationship to policy holder: ☐Self ☐Spouse/Partner (Member ID#: _____) ☐ Dependent	

SECONDARY INSURANCE PHONE (EACH CAN BE FOUND ON INSURANCE CARD)
Member's insurance toll free phone number:
Insurance notification/provider's toll-free phone:

CURRENT PROBLEM
What is the main reason for the person's visit to the clinic?
What were the person's initial symptoms and when did they develop?
When were these initial symptoms first observed?
Did the symptoms occur suddenly or develop gradually over time? ☐ Suddenly ☐ Gradually
Have the symptoms changed over time? ☐ Stable ☐ Stable, then sudden decline ☐ Steadily worsened ☐ Fluctuating ☐ Improved
Has the patient ever suffered symptoms of delirium? (periods of extreme confusion or disorientation due to illness, medication side-effects or being in the hospital) ☐ Yes ☐ No ☐ Don't Know If yes, please state the approximate year(s) and describe the event(s).

PEOPLE MAY EXPERIENCE CHANGES IN MANY ABILITIES. HELP US UNDERSTAND THE PERSON'S CURRENT ABILITIES BY MARKING THE BOXES BELOW.

MEMORY & THINKING – DOES SHE/HE HAVE PROBLEMS WITH:	Never	Sometimes	Often	Always
Recalling recent events	☐	☐	☐	☐
Recalling details of conversations	☐	☐	☐	☐
Repeating questions or stories	☐	☐	☐	☐
Misplacing or losing items	☐	☐	☐	☐
Forgetting dates, schedules, or appointments	☐	☐	☐	☐
Recognizing familiar places, people, or objects	☐	☐	☐	☐
Recalling events from the distant past	☐	☐	☐	☐
Learning a new route to an unfamiliar place	☐	☐	☐	☐
Becoming lost or confused in familiar places	☐	☐	☐	☐
Finding words or expressing thoughts	☐	☐	☐	☐

MEMORY & THINKING (CONTINUED)– DOES SHE/HE HAVE PROBLEMS WITH:

	Never	Sometimes	Often	Always
Understanding others	☐	☐	☐	☐
Making judgments or solving problems	☐	☐	☐	☐
Carrying out multi-step activities	☐	☐	☐	☐
Multitasking (performing two tasks at one time)	☐	☐	☐	☐
Focusing, concentrating, or being easily distracted	☐	☐	☐	☐

DAILY TASKS – DOES SHE/HE HAVE PROBLEMS WITH THESE ACTIVITIES (SPECIFICALLY RELATED TO CHANGES IN MEMORY & THINKING):

	N/A*	Never	Sometimes	Often	Always
Medications					
Preparing/organizing medications	☐	☐	☐	☐	☐
Recalling use and/or dosage	☐	☐	☐	☐	☐
Forgetting to take medications	☐	☐	☐	☐	☐
Making other medication errors	☐	☐	☐	☐	☐
Finances					
Preparing/completing taxes	☐	☐	☐	☐	☐
Organizing/preparing bill payment	☐	☐	☐	☐	☐
Bill payment (paying late or twice)	☐	☐	☐	☐	☐
Managing checkbook/online account	☐	☐	☐	☐	☐
Calculating a tip	☐	☐	☐	☐	☐
Making change	☐	☐	☐	☐	☐
Household Tasks					
Shopping or making purchases	☐	☐	☐	☐	☐
Cooking, grilling, or preparing food	☐	☐	☐	☐	☐
Household chores or simple repairs	☐	☐	☐	☐	☐
Doing laundry	☐	☐	☐	☐	☐
Arranging transportation	☐	☐	☐	☐	☐
Using a telephone	☐	☐	☐	☐	☐
Using technology (tools, microwave, thermostat, computer, smartphone)	☐	☐	☐	☐	☐

*Please check the N/A box if the person has never performed the task(s) or you do not know.

PERSONAL CARE AND GROOMING – HOW DOES SHE/HE COMPLETE THESE ACTIVITIES:	Completely Independent	Verbal reminders	Physical assistance	Completely Dependent
Shaving	☐	☐	☐	☐
Combing/styling hair	☐	☐	☐	☐
Brushing teeth	☐	☐	☐	☐
Applying or removing makeup, if applicable	☐	☐	☐	☐
Bathing or showering	☐	☐	☐	☐
Dressing or undressing	☐	☐	☐	☐
Eating using utensils	☐	☐	☐	☐
Chewing and swallowing correctly/safely	☐	☐	☐	☐
Using the toilet	☐	☐	☐	☐

JUDGMENT AND SAFETY - DOES SHE/HE HAVE PROBLEMS WITH:	
☐ Leaving the stove on or microwave fires	☐ Wandering off or getting lost
☐ Leaving the water on	☐ Forgetting to eat
☐ Having trouble regulating the thermostat	☐ Living alone or being left alone
☐ Having access to weapons or power tools	☐ Being susceptible to solicitors

Does the person currently drive a motor vehicle? ☐ Yes ☐ No

If he/she drives, are you concerned about his/her safety? ☐ Yes ☐ No

If you answered "Yes" to the question above, please check any of the following areas of concern.

☐ Drives too fast	☐ Gets angry or flustered	☐ Straddles lanes
☐ Drives too slow	☐ Turns in front of other cars	☐ Runs overs curbs
☐ Gets lost	☐ Hits/scrapes objects	☐ Doesn't pay attention
☐ Recent accidents/citations	☐ Trouble parking	☐ Other:

MOOD AND BEHAVIOR: Please answer the following questions based on changes that have occurred since the patient first began to experience memory problems. Check the box only if the symptom(s) has been present **in the last month.**

	Not Applicable	Mild	Moderate	Severe
Does the patient have false beliefs, such as thinking that others are stealing from him/her or planning to harm him/her in some way?	☐	☐	☐	☐
Does the patient have hallucinations, such as false visions or voices? Does he/she seem to hear or see things that are not present?	☐	☐	☐	☐
Is the patient resistive to help from others at times or hard to handle?	☐	☐	☐	☐
Does the patient seem sad, or say that he/she is depressed?	☐	☐	☐	☐
Does the patient become upset when separated from you? Does he/she have any other signs of nervousness such as shortness of breath, sighing, being unable to relax or feeling excessively tense?	☐	☐	☐	☐
Does the patient appear to feel too good or act excessively happy?	☐	☐	☐	☐
Does the patient seem less interested in his/her usual activities, or in the activities or plans of others?	☐	☐	☐	☐
Does the patient seem to act impulsively, for example, talking to strangers as if he/she knows them or saying things that may hurt people's feelings?	☐	☐	☐	☐
Is the patient impatient and cranky? Does he/she have difficulty coping with delays or waiting for planned activities?	☐	☐	☐	☐
Does the patient engage in repetitive activities such as pacing around the house, handling buttons, wrapping string or doing other things repeatedly?	☐	☐	☐	☐
Does the patient awaken you during the night, rise too early in the morning or take excessive naps during the day?	☐	☐	☐	☐
Has the patient lost or gained weight, or had a change in the type of food he/she likes?	☐	☐	☐	☐

PERSONALITY AND BEHAVIOR:

Please check any of the following words that describe her/his life-long PERSONALITY:

☐ Even tempered	☐ Quick tempered	☐ Optimistic	☐ Pessimistic
☐ Socially outgoing	☐ Homebody	☐ Worrier	☐ Stubborn
☐ Low self-esteem	☐ Assertive	☐ Manipulative	☐ Complainer
☐ Hypochondriac	☐ Generous/caring	☐ Good sense of humor	

Has the patient experienced any CHANGES in personality or behavior, such as:

☐ Increased impulsivity	☐ Reduced frustration tolerance	☐ Increased irritability
☐ Agitation	☐ Difficulty getting started	☐ Reduced motivation
☐ Loss of empathy	☐ Socially inappropriate behavior	☐ Restlessness
☐ Risky behaviors	☐ Social withdrawal	☐ Other, describe:

SLEEP - DOES SHE/HE HAVE PROBLEMS WITH:

☐ "Acting out dreams" while sleeping (punching or flailing arms in the air, shouting or screaming)	☐ Legs repeatedly jerking or twitching during sleep (not just when falling asleep)
☐ A restless, nervous, tingly, or creepy-crawly feeling in legs that disrupts falling/staying asleep	☐ Walking around the bedroom or house while asleep
☐ Snorting or choking him/herself awake	☐ Seem to stop breathing during sleep
☐ Increased need for sleep	☐ Excessive daytime sleepiness/drowsiness
☐ Difficulty falling asleep	☐ Difficulty staying asleep

CAREGIVER CONCERNS-IF YOU ARE A CAREGIVER, WHICH OF THE AREAS BELOW CONCERN YOU?

Financial/legal	☐ YES	If yes, please describe
Physical health	☐ YES	If yes, please describe
Mental health	☐ YES	If yes, please describe
Managing problem behaviors	☐ YES	If yes, please describe
Decisions about alternative care options	☐ YES	If yes, please describe
Other	☐ YES	If yes, please describe

MEDICAL HISTORY

Check below if the patient has experienced any of the following?

☐ Head trauma or brain injury ☐ Loss of consciousness ☐ Stroke or TIA (mini-stroke)
☐ Difficulty walking, falls ☐ Exposure to toxins ☐ Brain infections
☐ Seizures ☐ Other neurological condition(s): If

you checked any of the above, description(s) and date(s):

Please list any birth injuries or illnesses:

Please list any childhood/adolescent injuries or illnesses:

Any history of learning disability or ADD/ADHD? ☐ Yes ☐ No
Did the patient ever repeat a grade or receive special education? ☐ Yes ☐ No
If yes to either of these questions, please describe:

Check below if the patient has the following conditions and/or is treated for the following conditions?

☐ High blood pressure ☐ Atrial fibrillation ☐ High cholesterol ☐ Diabetes
☐ Sleep apnea ☐ Other cardiac abnormalities

Has the patient had a brain scan? ☐ Yes ☐ No	
If yes, location:	Date:
Has the patient had a neuropsychological evaluation? (usually over 2 hours of testing of thinking skills) ☐ Yes ☐ No	
If yes, by whom:	Date:

MEDICATION HISTORY

ALLERGIES

Please list allergies to medications:

Please list allergies to foods:

Please list other allergies:

PLEASE LIST ALL MEDICATIONS TAKEN WITHIN THE LAST MONTH:

PRESCRIPTION MEDICATIONS					
DRUG NAME	DOSE	TIMES PER DAY	DATE STARTED	DATE STOPPED	MEDICAL CONDITION BEING TREATED
NONPRESCRIPTION MEDICATIONS, SUPPLEMENTS, VITAMINS					
DRUG NAME	DOSE	TIMES PER DAY	DATE STARTED	DATE STOPPED	MEDICAL CONDITION BEING TREATED

PLEASE LIST PAST AND CURRENT MEDICAL, NEUROLOGICAL AND PSYCHIATRIC PROBLEMS

PROBLEM	DIAGNOSIS DATE	ACTIVE
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

SURGICAL HISTORY		
TYPE OF SURGERY	**HOSPITAL**	**DATE**

HOSPITALIZATIONS		
REASONS FOR HOSPITALIZATION	**HOSPITAL**	**DATE**

SYSTEM REVIEW

PLEASE REVIEW THIS AND CHECK "YES" FOR ANY SYMPTOMS THE PATIENT IS CURRENTLY EXPERIENCING

YES	CONSTITUTIONAL
☐	Chills
☐	Fatigue
☐	Fever
☐	Malaise (general discomfort)
☐	Night sweats
☐	Weight gain
☐	Weight loss

YES	HEAD, EYES, EARS, NOSE, THROAT (HEENT)
☐	Ear drainage
☐	Ear pain
☐	Eye discharge
☐	Eye pain
☐	Hearing loss
☐	Nasal drainage
☐	Sinus throat
☐	Visual changes

YES	RESPIRATORY
☐	Chronic cough
☐	Cough
☐	Known TB exposure
☐	Shortness of breath
☐	Wheezing
☐	Asthma

YES	CARDIOVASCULAR
☐	Chest pain
☐	Leg pain with walking
☐	Edema
☐	Palpitations (abnormal heart beats)

YES	GASTRO-INTESTINAL
☐	Abdominal pain
☐	Blood in stools
☐	Change in stools
☐	Constipation
☐	Diarrhea
☐	Heartburn
☐	Loss of appetite
☐	Nausea
☐	Vomiting

YES	GENITOURINARY
☐	Dribbling
☐	Burning with urination
☐	Blood in urine
☐	Excessive urination
☐	Slow stream
☐	Urinary frequency
☐	Urinary incontinence
☐	Urinary retention

YES	REPRODUCTIVE
☐	Erectile dysfunction (men)
☐	Penile/vaginal discharge
☐	Sexual Dysfunction
☐	Abnormal Pap smear (women)
☐	Breast discharge or lump (women)
☐	Painful menstrual periods (women)
☐	Pain with intercourse
☐	Hot flashes (women)
☐	Irregular menstrual periods (women)

YES	METABOLIC/ENDO
☐	Brittle hair
☐	Brittle nails
☐	Cold intolerance
☐	Hair changes
☐	Heat intolerance
☐	Excessive hair growth
☐	Excessive thirst
☐	Excessive eating

YES	NEUROLOGICAL
☐	Dizziness
☐	Extremity numbness
☐	Extremity weakness
☐	Walking or balance problems
☐	Headache
☐	Memory loss
☐	Seizures/convulsions
☐	Tremors
☐	Sudden loss of consciousness

YES	PSYCHIATRIC
☐	Anxiety
☐	Depression
☐	Insomnia

YES	SKIN
☐	Contact allergy
☐	Hives
☐	Itching
☐	Mole changes
☐	Rash
☐	Skin lesion

YES	MUSCULO-SKELETAL
☐	Back pain
☐	Joint pain
☐	Joint swelling
☐	Muscle weakness
☐	Neck pain

YES	HEMOTOLOGIC/ LYMPHATIC
☐	Easy bleeding
☐	Easy bruising
☐	Swollen glands

YES	IMMUNOLOGIC
☐	Environmental allergy
☐	Food allergy
☐	Seasonal allergy

PHYSICIAN NOTES

SOCIAL HISTORY

Highest level of formal education completed:

☐ Less than high school ☐ GED ☐ High school
☐ Some college ☐ Associate degree ☐ Bachelor's degree
☐ Master's degree ☐ Doctoral degree

Retired: ☐Yes ☐No If yes, year retired:

If working, current occupation:	If no longer working, prior occupation:
Years in current occupation:	Years in occupation:
Currently working: ☐ Part-time ☐ Full-time	Worked: ☐ Part-time ☐ Full-time

Hobbies/Interests

Does/did memory and thinking problems affect(ed) working or hobbies? ☐ Yes ☐ No

Number of living children: Number of daughters: Number of sons:

Current living situation:

☐ Alone in home/apt ☐ With spouse/significant other ☐ With other family or friends
☐ Assisted living ☐ Nursing home ☐ Other:

SUBSTANCE USE HISTORY

TOBACCO USE

Does the patient currently smoke? ☐ Yes ☐ No	
If yes: # of packs per day:	# of years smoked:
Did the patient ever smoke in the past? ☐ Yes ☐ No	If yes, year quit:
If patient ever smoked, # of packs per day:	# of years smoked:

ALCOHOL USE

Current use: How many drinks per week?

Past use: How many drinks per week?

Any history of excess use (now or in the past)? ☐ Yes ☐ No

SUBSTANCE USE

Has the patient used medical marijuana, recreational drugs, and/or misused prescription medications recently and/or in the past? ☐ Yes ☐ No

If yes:	Type:	Duration:

FAMILY HISTORY

DOES THE PATIENT HAVE A BLOOD RELATIVE WITH SYMPTOMS OF OR DIAGNOSIS OF:

Dementia/Senility/Alzheimer's? ☐ Yes ☐ No If yes, relationship and age of onset of memory problems:		
Parkinson's disease? ☐ Yes ☐ No		If yes, relationship:
Strokes? ☐ Yes ☐ No		If yes, relationship:
Psychiatric/Mental Illness? ☐ Yes ☐ No		If yes, relationship:
Intellectual disability? ☐ Yes ☐ No		If yes, relationship:
How many brothers: How many sisters:		
Does the patient have living siblings without dementia? ☐ Yes ☐ No		
Please list diseases/illnesses in your family:		
Mother:		
Father:		
Siblings: • Brothers: • Sisters:		
Children:		
Grandparents: • Mother's side: • Father's side:		

Mountainview Clinical Psychology, PLLC

Cancellation Policy & Patient Financial Responsibility

GUARANTEE OF PAYMENT AND ASSIGNMENT OF INSURANCE BENEFITS: For value received, the undersigned guarantor and/or patient (hereinafter the "Responsible Party") promises to pay to Mountainview Clinical Psychology, PLLC all charges incurred for services rendered to the Responsible Party. The Responsible Party understands that Mountainview Clinical Psychology, PLLC will process the paperwork to complete insurance claim(s) but only as a courtesy to the Responsible Party, and the Responsible Party authorizes Mountainview Clinical Psychology, PLLC to release any and all medical information necessary to complete insurance claim(s) and assigns any monies due and owing under the insurance contract to Mountainview Clinical Psychology, PLLC. It is, however, understood and agreed that the Responsible Party is responsible for all monies due and owing for services rendered by Mountainview Clinical Psychology, PLLC in the event insurance does not pay for these services. It is acknowledged that the ultimate completing and following-up of any insurance claims is the responsibility of the Responsible Party. The Responsible Party authorizes use of this form on all insurance claim submissions. Release of records to referral sources is also authorized. The Responsible Party agrees to be bound by the terms and conditions of this account with Mountainview Clinical Psychology, PLLC.

Your copay is expected at the time of service. We will file the Responsible Party's initial insurance claim(s) and provide documentation necessary for insurance reimbursement. We do not, however, guarantee that each service will be covered or what percentage will be covered. In the event that the Patient's/Responsible Party's insurance does not cover our services (or any portion thereof), Mountainview Clinical Psychology, PLLC will work with the Responsible Party regarding payment (e.g., setting up a payment plan).

Responding to Forensic/Medical Legal requests, conferences and telephone calls with attorneys involve additional time and record keeping. The Responsible Party is responsible for all direct costs and expenses associated with Mountainview Clinical Psychology, PLLC and its attorney responding to discovery requests (including depositions and subpoena duces tecum time and labor costs) and with conferences including, but not limited to court appearances, preparation of reports, photocopying, faxes, out of office travel, overnight delivery and courier services. These expenses are billed to the Responsible Party and to the Patient's/Responsible Party's Attorney. The Responsible party, however, remains responsible for payment of these charges if not paid in full within sixty (60) days.

Cancellation Policy:

Testing Appointments:

All testing appointments must be confirmed within 3 business days prior to the appointment. If we are unable to secure a confirmation from you within 3 business days of the appointment, your appointment will be cancelled and filled with another patient. **Be sure to respond to appointment reminder texts or phone calls to secure your appointment.** A minimum of 48 hours' notice is required for cancellation of confirmed testing appointments. These appointments are blocked off for large periods of time (3-4 hours), reserved only for the patient. If this notice is not received, the Responsible Party will be charged a no-show fee ($250 for neuropsychological evaluation) which was reserved for the appointment at the rates posted in the office of Mountainview Clinical Psychology, PLLC. Insurance will not be billed for missed/canceled appointments.

60-minute Intake/Feedback appointments:

A minimum of 24 hours' notice is required for cancellation of confirmed intakes/feedbacks. The no-show fee for confirmed intake/feedback appointments is $50.

If you have any questions, please speak with Dr. Husk/Dr. Mahan. Your signature indicates that you have read the above and agree to the terms contained therein. These agreements are irrevocable.

Responsible Party: _____ Signature: _____

Date: _____

Guardian Signature (if patient unable to sign**): _____

MOUNTAINVIEW CLINICAL PSYCHOLOGY, PLLC
KRISTI HUSK, PSY.D., ABN, CBIS

14300 N. Northsight Blvd. Ste. 215, Scottsdale, AZ 85260
p 480-280-6618 f 855-850-8159

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____ _____
(Print Full Name) (Date of Birth)
hereby authorize the release of my health information

To/from:

Mountainview Clinical Psychology, PLLC
14300 N. Northsight Blvd., Suite 215
Scottsdale, AZ 85260
Fax: 855-850-8159 Phone: 623-414-3279

To/from:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information.

Purpose of disclosure: _____

Information requested: _____

I give my permission for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire 90 days after the date signed. The requestor should not redisclose my medical record to another party without further written consent. I will not hold Dr. Husk nor Mountainview Clinical Psychology, PLLC liable for any injury, whether mental or physical, resulting from any misunderstanding of information in the released report as a result of my not asking Dr. Husk for clarification of the information therein.

Date: _____ Signature: _____
(Patient or Legal Representative)

Date: _____ Witness: _____