

Desert Vista Counseling Services, L.L.C.

www.desertvistacounseling.com

Mesa Location
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Fax: 623-565-8016

Scottsdale Location
7403 E. 6th Ave., Suite 5
Scottsdale, AZ 85251
Ph: 480-946-3082
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Consent to use and disclose your health information

This form is an agreement between you, _____ and Desert Vista Counseling Services, L.L.C. When we refer to the word “you”, it can apply to you, your child, a relative, or other person if the name is written here _____.

When we examine, test, diagnose, treat, provide services, or refer you to another provider, we will be collecting what the law refers to as Protected Health Information (PHI). We will use this information to decide on treatment/services to provide and to be able to provide you treatment/services. We are also able to use and share this information with others who provide you treatment or to arrange payment for the treatment/services we provide or other business/government functions.

By signing below, you agree to let us use this information here and send it to others such as your insurance company. The Notice of Privacy Practices explains in more detail your privacy rights and how we can use and disclose your information. 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.

In the future, we may change how we use and share your information so we may change our Notice of Privacy Practices. If we do so, we will provide you an update copy.

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 by writing a letter to our Privacy Officer Dr. Lisa Gold, informing us of your wishes. 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

Signature of client or personal representative Date

Relationship to client/Description of personal representative's authority

Signature of authorized representative of this practice

Date of NPP _____

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