**ARIZONA ADVANCED HEALTH SERVICES**

Authorization & Consent

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OFFICE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT TO TREATMENT:**I have been fully informed and understand the nature of the services provided by Arizona Advanced Health Services psych providers for mental wellness in chronic care management. I consent to evaluation and treatment with mental health services as ordered by my physician and / or requested by my family or self.

**CONFIDENTIALITY:** Under most circumstances the communications between a therapist and a client are held confidential. In the case of: 1) Danger to self or others. 2) A valid court subpoena: or 3) Existing or suspected abuse (physical, mental, financial, or verbal); your therapists is required to waive confidentiality and specific actions.

**LIMITED WAIVER OF CONFIDENTIALITY:** Because your progress notes will be contained in your facility medical chart, standard confidentiality is not possible. Professional staff from the facility and your physician or consulting physicians will have access to this medical chart. Generally, in circumstances such as this, limited waivers of confidentiality are established. Unless otherwise indicated in writing, you agree to the following limited waivers: 1. Release of information between your attending physician/consulting physicians and your mental health service provider. 2. Release of information between professional facility staff and your mental health service provider.

**SPECIFIC WAIVER OF CONFIDENTIALITY:** I **DO / DO NOT** *(circle one)* give permission for my mental health service provider to discuss my situation with my immediate family members. I **DO / DO NOT** *(circle one)* give permission for my mental health service provider to discuss my situation with my POA/ Health Care Surrogate if I have one appointed. Unless revoked in writing this authorization and consent shall remain in effect for one year after termination of services.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_**

 **Patient Signature (POA/Guardian/Health Care Surrogate Signature)**

**Relationship to Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_if patent DOES NOT OR CANNOT SIGN, explain why here:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **PRINT NAME SIGNATURE DATE**

**This section applies and is necessary ONLY when getting VERBAL (PHONE) consent. Write the name, address and phone number of the designated person giving the verbal phone consent in the box below and complete the telephone summary information below.**

**PHONE COMMUNICATION SUMMARY: Date of communication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time of Communication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spoke to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(legal designation and relationship to resident) Who authorized/ requested mental health treatment for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(resident).**

**FACILITY STAFF SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TITLE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and Address of person giving legal consent: Phone:**

**If completed by family/legal designee:**

**According to the phone contact described above, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize mental**

 **(Family Member/POA signature only)**

**Health treatment described for :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Resident’s Name)**