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Name:
DOB:
AHCCCS ID:
Client Id:
Appointment Date:

Agreement to Treatment Participation

I am in agreement that I will be involved with the Behavioral Health Services of the Marana Health Center, either as a client or as a parent or guardian of a client. I also understand that it is my responsibility to notify the therapist of any cancellation, address changes, or changes in payment source. I will also notify the Behavioral Health Services immediately of any significant changes in behavior or mental status. I understand that my consent is voluntary and may be withdrawn at any time, with the exception of a court mandate.

I understand that MHC adheres to all HIPAA guidelines for protected health information. In MHC's endeavor to provide me with the highest quality of care, I give permission for MHC staff to utilize 'data' pertaining to my visits and/or treatment in their analysis for improving outcomes. I understand that at no time will my name, address or any other identifying information be used in these analyses.

Per this agreement, if applicable, I will take my medications as prescribed, report any side effects and inform my treatment team of any medications prescribed to me by any practitioner.

In the event of an emergency, I authorize Behavioral Services Staff to dial 911 and/or provide CPR or first-aid, if necessary, until emergency personnel arrive.

_____

Signature of Client Date

_____

Printed Name

_____

Signature of Parent or Legal Guardian Date

_____

Staff Signature Date

Name:
DOB:
AHCCCS ID:
Client Id:
Appointment Date:

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Patient-Client Rights

Marana Health Center (MHC) Policy: AD-3-013, Patient-Client Rights

MHC patients/clients have the right to:

1. Be treated with dignity, respect, and consideration
2. Not be subjected to:
   a. Abuse;
   b. Neglect;
   c. Exploitation;
   d. Coercion;
   e. Manipulation;
   f. Sexual abuse;
   g. Sexual assault;
   h. Except as allowed in R9-10-1012(B), restraint or seclusion;
   i. Retaliation for submitting a complaint to the department or another entity; or
   j. Misappropriation of personal and private property by an outpatient treatmentcenter's personnel member, employee, volunteer, or student;
3. A patient/client or the patient's/client's representative:
   a. Except in an emergency, either consents to or refuses treatment;
   b. May refuse or withdraw consent for treatment before treatment is initiated;
   c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure;
   d. Is informed of the following:
      i. The outpatient treatment center's policy on health care directives, and
      ii. The patient complaint process;
   e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes; and
   f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
      i. Medical record, or
      ii. Financial records.

Provider of Care:

Name:
DOB:
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Appointment Date:

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4. A patient/client has the following rights:
   a. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
   b. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
   c. To receive privacy in treatment and care for personal needs;
   d. To review, upon written request, the patient's own medical record according to A.R.S. 12-2293, 12-2294, and 12-2294.01;
   e. To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
   f. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
   g. To participate or refuse to participate in research or experimental treatment; and
   h. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.
   i. If you are a Cenpatico Integrated member, you have the rights described above as well as the Cenpatico member Rights and Responsibilities provided to you at the time of your intake, and available on the Cenpatico website at <https://www.cenpaticointegratedcareaz.com/members/rights---responsibilities.html>

_____

Signature of Patient/Client Date

_____

Printed Name

_____

Signature of Parent or Legal Guardian Date

_____

Staff Signature Date

Provider of Care:

Name:
DOB:
AHCCCS ID:
Client Id:
Appointment Date:

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Privacy Notice

(THIS NOTICE DESCRIBES HOW MEDICAL, DENTAL, AND MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION)

PLEASE REVIEW CAREFULLY

WHO WILL FOLLOW THIS NOTICE

This notice describes the practices of the Marana Health center, Inc. (MHC) regarding the use of your health information and that of:

- Any of our healthcare professionals authorized to enter information into your medical, dental, or behavioral health record
- All departments and units of the Marana Health Center
- Any member of a volunteer/student group we allow to help you while you are in our facility
- All employees, contracted staff, and other Marana personnel
- All affiliates, sites and locations of the Marana Health Center will follow the terms of this notice. In addition, these affiliates, sites, and locations may share health information with each other for the treatment, payment, or health care purposes described in this notice

OUR PLEDGE REGARDING YOUR HEALTH CARE INFORMATION

We understand that medical information about you and your health is personal. Protecting medical information about you is important. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated at the Marana Health Center, whether made by health care professionals or other personnel.

This notice will tell you about the ways in which we may use and disclose healthcare information about you. Disclosure, as appropriate, may be verbal communication, electronic transmission, paper record, or by fax. We also describe your rights and certain obligations we have regarding the use and disclosure of healthcare information.

We are required by law to:

- Keep personal healthcare information private;
- Give you this notice of our legal duties and privacy practices with respect to your healthcare information; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTHCARE INFORMATION ABOUT YOU

The following examples of the types of permitted uses and disclosures of your protected healthcare information. These examples are not meant to be all inclusive, but rather to describe the types of uses and disclosures that may be made by our office once you have provided consent.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

- For Treatment. Information obtained by a nurse, provider, or other member of your healthcare team will be recorded in your healthcare record and used to determine the course of treatment that should work best for you. We may disclose your health information to others who will need this information in order to treat you, for example another MHC provider, nurse practitioners, pharmacist, or others involved in your care. We may also disclose your protected health information to another healthcare provider (e.g. a specialist or laboratory) who, at the request of your MHC provider, becomes involved in your care by providing assistance with our healthcare diagnosis or treatment.
- For Payment. We may use and disclose your protected health information for billing and collection purposes. For example, we may need to give your 3rd party payer/Health Plan Information about your care so that they will pay us or reimburse you for this care. We may also provide information to your Health plan or 3rd party payer about a treatment/service that has been ordered by your healthcare provider in order to obtain prior approval or to determine whether your plan will cover the treatment/service.
- For Healthcare Operations. We may use or disclose, as needed, your personal health information in order to support out business activities. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities.
    - Other examples of healthcare operations might include:
        - Use of sign-in sheet at the front desk where you will be asked to sign your name.
        - Calling you by name in the waiting room when your healthcare provider is ready to see you.
        - We may contact you (by telephone or mail) to remind you about your appointment.

Provider of Care:

Name:
DOB: (
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Appointment Date:

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We will share your personal health information with 3rd party 'business associates' that perform various activities for MHC. Whenever an arrangement between our offices and a business associate involves the use or disclosure of your personal health information, we will have a written contract that contains terms that we will protect the privacy or your health information. Some examples of our business associates would include X-ray interpretation services, contracted laboratory testing, medical transcription services, record copy service, and record storage facilities.

II. OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITH YOUR CONSENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT

- Individuals involved in your care or payment for your care. Unless you object in advance, we may release protected health information about you to a friend or family member who is involved in you medical care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may also give information to someone who helps pay for your care. In addition, we may disclose personal health information about you to an authorized entity assisting with disaster relief efforts. We may allow family or friends to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, and similar forms of personal health information, when we determine, in our professional judgment that it is in your best interest to make such disclosures.
- Emergencies. We may use or disclose your protected health information in an emergency treatment situation should you be unable to consent prior to treatment. If this happens, we shall try to obtain your consent as soon as reasonably practicable after the treatment. If we are required by law to treat you and are unable to obtain your consent, we may still use or disclose your protected health information to treat you.
- Treatment Alternatives. We may use or disclose your personal health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.
- Marketing/Fundraising Activities. We may use or disclose your demographic information in order to contact you for marketing or fundraising activities supported by our clinic. (For example, your name and address may be used to send you a newsletter about our organization and the services we offer). If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

III. OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT

- As required by law. We will disclose your personal health information when required to do so by federal, state, or local law.
- Research. We may disclose your personal health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your personal health information. For example, we may conduct a research project involving the review of healthcare records for all patients with specific types of medical conditions.
- Public Health Risks. We may disclose your personal health information for public health activities. These activities generally include the following:
    - To prevent or control disease, injury, or disability
    - To report deaths
    - To report child abuse or neglect
    - To report reactions to medications or problems with products
    - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
    - To notify the appropriate authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.
- Worker's Compensation. We may release your personal health information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- Coroners, Funeral Directors, and Organ Donation. We may release your personal health information to a coroner or medical examiner to assist with identifying the deceased or determining the cause of death. We may release your personal health information to a funeral director as necessary to carry out their duties. If you are an organ donor, we may release your personal health information to organ procurement organizations of other entities in the procurement, banking, or transplantation or organs for the purpose of tissue donation and transplant.

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- Military and Veterans. If you are a member of the armed forces, we may release your personal medical information as required by military command authorities.
- Health Oversight Activities. We may disclose your personal health information to a health oversight agency for activities authorized by law. Examples of oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- Legal Proceedings. We may release your personal health information in response to a subpoena, discovery request, or other lawful orders from a court or administrative tribunal (to the extent such disclosure is expressly authorized).
- Law Enforcement. We may release your health information if asked to do so by a law enforcement activities; in investigations of criminal conduct of or victims of crime; in response to court orders; in emergency circumstances or whenever required to do so by law.
- Inmate. We may use or disclose your personal health information if you are an inmate of a correctional facility and your healthcare provider created or received your personal health information in the course of providing care to you.
- Protected Services for the President, National Security, and Intelligence Activities. We may release your personal health information to authorized federal officials so they may provide protection to the President, other authorized persons of foreign heads of state or conduct special investigations, or for intelligence, counterintelligence, and other national security activities authorized by law.

IV. USES AND DISCLOSURES OF PERSONAL HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION

- Other uses and disclosures of your personal health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose your personal health information, you may revoke this authorization, at any time, in writing. If you provide us permission to use or disclose your personal health information, you may revoke this authorization, at any time, in writing. If you revoke your permission, thereafter we will no longer use or disclose your personal health information for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you.

YOUR RIGHTS REGARDING MEDICAL INFORAMTION ABOUT YOU

Although your healthcare record is the physical property of Marana Health Center, the information belongs to you. You have the following rights regarding the healthcare information we maintain about you:

- Right to inspect and copy. You have the right to inspect and obtain a copy of healthcare information that may be used to make decisions about your care. Usually, this includes medical, dental, prescription, and billing records, but does not include psychotherapy notes.
    - To inspect and obtain a copy of healthcare information that may be used to make decisions about you, you must submit a written request to our medical Records Department. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and obtain a copy in certain very limited circumstances. If you are denied access to health information, you may deny your request to inspect and obtain a copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Marana Health Center will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- Right to Amend. If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. If addition, we may deny your request if you ask us to amend information that
    - Was not created by us;
    - Is not part of the medication information kept by the Marana Health Center;
    - Is not part of the information which you would be permitted to inspect and copy; or
    - Is accurate and complete

Provider of Care:

Name:
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- Right to Request Restrictions. You have the right to request a restriction or limitation on the personal health information we use or disclose about your for treatment, payment, or healthcare operations. You also have the right to request a limit on the personal health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request with one exception*. If we do agree we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to our Privacy Officer at the address below. In your request you must tell us:
    - What information you want us to limit;
    - Whether you want to limit our use of your information, disclosure to outside entities or both, and
    - To whom you want the limits to apply.

  *Exception: When you are paying for services out of pocket and request we do not provide it to the Health Plan, we must comply with the request.
- Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
    - To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice at any time. You may request a copy of our most current privacy notice from our Registration Office or from the Privacy Officer.
- Breach Notification. A breach is, generally, an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the protected health information (PHI) such that the use or disclosure poses a significant risk or financial, reputational, or other harm to the affected individual. If a breach occurs, you will be notified the breach occurred no later than 60 days after the occurrence.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We reserve the right to make the revise or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice. The notice will contain on the first page, in the top right hand corner, the effective date.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the Marana Health Center or with the Secretary of the Department of Health and Human Services toll free at 1-877-696-6775. To file a complaint with the Marana Health Center, contact our Privacy Office at the address and phone number below. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

CONTACT PERSON

If you have questions about this notice, please contact:

Privacy Officer - Marana Health Center * 13395 N. Marana Main St * Marana, AZ 85653 * (520) 682-4111

_____

Signature of Client Date

_____

Printed Name

_____

Signature of Parent or Legal Guardian Date

_____

Staff Signature

Provider of Care:

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Name:
DOB:
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Client Id:
Appointment Date:

Confidentiality of Alcohol & Drug Abuse Patient Records

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside of the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless:

1. The patient consents in writing
2. The disclosure is allowed by a court order, or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation

Violation of the Federal law and regulations by a program is a crime. Suspected violation may be reported to appropriate authorities in accordance with Federal evaluation.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities. (See 42 U.S.C. 290dd-e and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations).

_____

Signature of Client Date

_____

Printed Name

_____

Signature of Parent or Legal Guardian Date

_____

Staff Signature Date

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Name:
DOB:
AHCCCS ID:
Client Id:
Appointment Date:

Duty to Warn

Policies and Procedures

Purpose: To clarify the duty to warn, mandatory reporting and immunity for disclosure if a client communicates to any staff member a threat of imminent serious physical harm to any individual(s) or report of abuse or neglect.

Procedure: If a client communicates a threat of imminent serious physical harm to any individual(s) and the client has apparent intent and ability to carry out the threat, the following will occur (per ADHS Policy 1406):

A. The mental health provider of the client will have a duty to warn the potential victim(s) consisting of a minimum of two (2) attempted telephone contacts, followed by a written notification within 24 hours.
B. The mental health provider will notify a law enforcement agency in the vicinity where the client or a potential victim resides.
C. The mental health provider will take reasonable steps to initiate proceedings for a voluntary or involuntary hospitalization, if appropriate.
D. The mental health provider will take any other precautions that a reasonable and prudent mental health provider would take under the circumstances.
E. There will be no cause of action against a mental health provider nor shall legal liability be imposed for breaching a duty to prevent harm caused by client unless the mental health provider fails to take responsible precautions when the client has communicated an explicit threat of serious harm to a clearly identified victim with the intent and ability to carry out such threat.
F. The mental health provider will be immune from liability resulting from any disclosure resulting from a client communication regarding a threat of serious harm to a clearly identified victim with the intent and ability to carry out such threat.

Procedure: Any person who is reasonably believes that a minor (under the age of 18 years) is or has been the victim of abuse or neglect, the following will occur (per ARS 13-3620):

A. The mental health provider will immediately file a report to the office of the peace or Department ad Child Safety

I have read and understand the Duty to Warn and Mandated Reporting policy of the Marana Health Center.

_____
Signature of Client Date

_____
Printed Name

_____
Signature of Parent or Legal Guardian Date

_____
Staff Signature Date

Name:
DOB:
AHCCCS ID:
Client Id:
Appointment Date:

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Appeal and Grievance Procedures

WHAT IS AN APPEAL AND HOW DO I FILE ONE?
An appeal is a formal disagreement with a decision or adverse action that has been made about your behavioral health services or your need for such services. Sometimes a decision is made that you do not need behavioral health services, that your services will be changed in some way, or that a request for service for you has been denied. When that happens, you will receive a notice which explains your right to appeal that decision and tells you how many days from the date of adverse action you have to file your appeal.

TO FILE AN APPEAL, YOU CAN:
Call Cenpatico Office of Grievance and Appeals, 1501 W. Fountainhead Pkwy #360, Tempe, AZ 85282 (866) 495-6738. If you need help with the appeal process, a Member Advocate is available Monday through Friday from 8:00am until 5:00pm.

Complete an appeal form or write a letter and send it the Cenpatico Office of Grievance and Appeals (1501 W. Fountainhead Pkwy #360, Tempe, AZ 85282 (866) 495-6738). You can get an appeal form my calling the Cenpatico office of Grievance and Appeals or at the provider agency where you receive your treatment. Any staff member at the agency providing your services can also assist you in filing your appeal. We will send you a letter within five (5) working days (seven (7) calendar days) after we receive your appeal. This letter may request your participation in a meeting called an informal conference to discuss the situation and the steps that could be taken to fix the problem. If the problem cannot be resolved at this informal conference, you will have the opportunity to take your appeal to higher levels within the Arizona State Government, up to and including an administrative hearing before an administrative law judge.

WHAT IS A GRIEVANCE AND HOW DO I FILE ONE?
The grievance process applies only to adults who are enrolled in Cenpatico's programs for persons with a Serious Mental Illness (SMI). This process is used when you believe your rights, as a person with a Serious Mental Illness, have been violated or that you have been abused or mistreated by staff of a behavioral health agency under contract with Cenpatico. When you are enrolled into the SMI program, you receive a listing of your rights and an explanation of how to file a grievance.

TO FILE A GRIEVANCE, YOU CAN:
Complete a grievance form or write a letter and send it to the Cenpatico Office of Grievance and Appeals. You can get a grievance form by calling the Cenpatico Office of Grievance and Appeals or the provider agency where you receive your treatment. Any staff member of the agency providing your services can also assist you in filing your grievance. We will send you a letter within five (5) working days (seven (7) calendar days) after we receive your grievance. This letter may request your participation in a meeting called an informal conference to discuss the situation and the steps that could be taken to fix the problem. If the problem cannot be resolved at this informal conference, you will have the opportunity to take your grievance to higher levels within the Arizona State Government, up to and including and administrative hearing before an administrative law judge. You have the right to file a complaint, appeal, or grievance without fear that the quality of your care and treatment will suffer.

TO TAKE YOUR APPEAL OR GRIEVANCE TO THE ARIZONA STATE GOVERNMENT:
You can notify the ADHS/Office of Grievance and Appeals at 150 N. 18th Avenue, Suite 210, Phoenix, AZ 85007 (602) 364-4582, or the ADHS/Office of Behavioral Health Licensure at 150 N. 18th Avenue, Suite 410, Phoenix, AZ 85007 (602) 364-2595.

_____

Signature of Client Date

_____

Signature of Parent or Legal Guardian Date

_____

Staff Signature Date

Provider of Care:

Name:
DOB:
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Appointment Date:

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Fee Agreement

The Marana Health Center - Behavioral Health Services accepts payment by some third payers, including Medicare.

Behavioral Health Services also accepts sliding fee scales for payment. Sliding scale fees are determined based on the client's ability to pay. The sliding fee takes into consideration the number of people living in the household. Documentation verifying monthly income of all the people in the household is requested for qualification for the sliding scale fee.

The Behavioral Health services will notify all clients of any charges in the fee schedule at least 30 days prior to changes in the fee schedule or payment criteria.

I understand that _____ is responsible for payment of charges for my behavioral health services.

If sliding fee scale or copays apply, I understand that I am responsible for a payment of $_____ per session.

_____

Signature of Client Date

_____

Printed Name

_____

Signature of Parent or Legal Guardian Date

_____

Staff Signature Date

Provider of Care:

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Name:
DOB:
AHCCCS ID:
Client Id:
Appointment Date:

Attendance Policy

The staff at the Behavioral Health Services of the Marana Health Center are attempting to serve all clients in a timely manner. In order to provide the best services in a timely manner, it is important that the client also be aware and respectful of the time allotted for their appointment.

If you are not able to attend an appointment we ask that you call 24 hours in advance. This will allow the Therapist and/or Recovery Coach to fill that allotted time with another client.

Due to the number of missed appointments and 'no shows' we have now instituted the following policy regarding attendance and termination of services.

Behavioral Health Services will be terminated if any of the following occur:

1. You have 2 'no show' appointments.
2. You have 3 missed appointments in a two-month period.
3. You have a pattern of missed appointments.

If services are terminated, you will be given a referral to obtain behavioral health services elsewhere.

Thank you for your understanding in this matter.

The Behavioral Health Staff
I understand and accept the attendance guidelines for Behavioral Health Services.

_____
Print Name

_____
Signature of Client Date

_____
Print name of Parent or Legal Guardian

_____
Signature of Parent or Legal Guardian Date

_____
Staff Signature Date

Provider of Care:

MHC Healthcare
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Name:
DOB:
AHCCCS ID:
Client Id:
Appointment Date

Permission to Leave Telephone Messages

I, _____ (client name) give my permission for Behavioral Health staff members to leave voicemail messages on my home and cell phones regarding any issues pertaining to my behavioral health medication, appointment scheduling or documentation needs.

I also give my permission for Behavioral Health staff to leave a message with any person that answers any of the contact phone numbers that I have provided.

If there is ever a time that I do NOT want a message left on my telephone, or with whoever answers, I will let my Recovery Coach know and complete a new form.

I understand that messages left WILL NOT contain specific information regarding my treatment goals or objectives or in any way divulge information regarding my specific behavioral health issues or progress.

_____

Signature of Client Date

_____

Printed Name

_____

Signature of Parent or Legal Guardian Date

_____

Staff Signature Date

_____

Phone Number

Provider of Care:

AHCCCS ID: Client Id:
Appointment Date:
Provider of care:

MHC Healthcare

Release of Confidential Information Authorization

Patient Name:	Date of Birth:
Address:	SSN #:

As an integrated care provider, Maraña Health Center (MHC) has access to your medical information, including any behavioral mental health or substance use information. Your consent is needed to share certain types of health information. This form allows you to provide consent to share information regarding: (1) behavioral mental health services and referrals, and (2) treatment for alcohol or substance use disorders. This form is consistent with the requirements listed in the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR 164; and 42 CFR Part 2.

Specific Individual/Entity:

To: _____

Address: _____

_____

Phone #: _____ Fax #: _____

General Designation/Entity:

- ☐ Residental programs
- ☐ Crisis-level hospitals
- ☐ Probation services
- ☐ Health homes
- ☐ Department of Child Saftey (DCS)

INFORMATION TO BE RELEASED (check all that apply):

____ Clinical assessment	____ HIV/AIDS	____ Test Results/Labs
____ Diagnosis/Prognosis	____ Treatment/Service plans	____ Medications
____ Discharge summary	____ Progress notes	____ Other (specify): _____

SPECIAL PURPOSE INFORMATION:

____ Substance use services (specify): _____

____ Psychotherapy notes. These notes must be requested seperately from all other records.

PURPOSE OF REQUEST: ☐ Referral ☐ Request of Individual ☐ Other (specify): _____

AUTHORIZATION WILL EXPIRE ON:

☐ Date: _____ ☐ Condition: _____

☐ Event: _____

ACKNOWLEDGMENT:

1. Revocation. I may revoke this authorization by submitting a written notice to *MHC Healthcare, 13395 N Marana Main St., Marana, AZ 85653*. Revocation will not affect records released before the revocation is received.
2. General Designations. Upon my request, I must be provided with a list of entities to which my information has been disclosed pursuant to a general designation.
3. Voluntary Consent. MHC may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
4. Redisclosure. Substance use information used or disclosed pursuant to this authorization is prohibited from redisclosure by the recipient without my authorization.
5. Copy of Authorization Form. I am entitled to a copy of this consent form.
6. Expiration. No authorization will be valid more than one (1) year from date of signature.

SIGNATURE OF PATIENT OR OTHER AUTHORIZED REPRESENTATIVE:

Patient Name (please print): _____

Authority: ☐ Parent ☐ Legal Guardian ☐ Personal Representative ☐ Other (specify): _____

Signature: _____ Date: _____

NOTICE TO RECIPIENTS OF CONFIDENTIAL INFORMATION:

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

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Name:
DOB:
AHCCCS ID:
Client Id:
Appointment Date:

Advance Directive Durable Mental Health Power of Attorney Form

An Advance Directive is a legal document that enables a person to direct his/her healthcare preferences in the event the client is unable to communicate them. MHC Healthcare has reviewed the following with respect to Advance Directives:

a. MHC has reviewed the function of Advance Directives and provided resources on where to learn more about developing an Advance Directive ___ Yes ____ No
b. The client have an existing Advance Directive ____ Yes ____ No
c. MHC has/will be provided a copy of the Advance Directive ____ Yes ____No
d. If no Advance Directive, the client would like to complete an Advance Directive ____ Yes ____ No
e. The client would like assistance in developing an Advance Directive ____ Yes ____ No

If you would like more information on Advanced Directives, or want to create an Advance Directive, please refer to the Cenpatico Member Handbook at www.cenpaticoaz.com.

_____

Signature of Client Date

_____

Printed Name

_____

Signature of Parent or Legal Guardian Date

_____

Staff Signature Date

Name:
DOB:
Appointment Date:
Provider of Care:

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Minor Child Release and Consent to Treat Form

The Confidentiality of our patient's medical and dental information is very important to us. We understand there may be circumstances in which another individual may need to care for your child. The Arizona law requires consent of parent / legal guardian for medical care of minors. In order to provide medical care, we must require you to provide the following information.

Please list the names of authorized individuals who have your permission to be involved in your child's medical care. This permission will include appointments, medical decision- making, authorizing treatment, and authorization to release test results. Please appoint three authorizing adults to bring in child to MHC.

I,_____(Print name here), am the parent/legal guardian of

_____ (Print name here), currently a minor, whose date of birth is / / .

I authorize,

1. _____who is my child's,_____(Relationship to Patient)

and their Phone Number is: _____

2._____who is my child's,_____ (Relationship to Patient)

and their Phone Number is: _____

3._____who is my child's,_____(Relationship to Patient)

and their Phone Number is: _____

I do hereby consent to any medical care for the welfare of my child while child is under the care of the above listed person(s).

_____ I DO hereby consent for my child who is over the age of sixteen (16) to attend medical
Initial appointments without an authorized escort.

_____I DO NOT authorize anyone other than myself, as legal guardian of the above listed patient, to
Initial escort and/or authorize medical care.

Note: Photo identification will be required prior to registration of patient with authorized personnel.

_____ _____
(Print) Name of Parent/ Legal Guardian Signature of Parent/Legal Guardian

_____
Date