EVERNORTH
HEALTH SERVICES

Consent for Behavioral Health Services and Disclosure of Information

Patient Name: _____

Date of Birth: _____ **Medical Record Number (MRN):** _____

I, (the patient named above or his or her representative), hereby voluntarily consent to receive behavioral health services provided by a Behavioral Health Clinician, working with Evernorth Behavioral Care Group.

I agree that an electronic medical record will be used to document the Behavioral Health screening, assessment, treatment plan, and progress toward my treatment goals. Any psychotherapy note containing the content of a therapy session with the Behavioral Health Clinician is secure and will be disclosed only if I provide a separate and distinct consent to disclose.

This consent is effective for the duration of treatment.

RIGHT TO REVOKE

My consent shall remain in effect until revoked in writing or at the termination of treatment. I understand that I have the right to revoke this Consent at any time during the treatment process by providing written notice to Evernorth Behavioral Care Group.

X _____ _____ ☐ AM ☐ PM

Patient Signature **Date / Time**

_____ _____

Legal Representative Signature **Relationship to patient**

_____ _____ ☐ AM ☐ PM

Behavioral Health Clinician Signature **Date / Time**

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I, (the patient named above or his or her representative), hereby voluntarily consent to the disclosure of my Behavioral Health Assessment by Evernorth Behavioral Care Group to my Primary Care Provider as identified by my health plan.

My signature authorizes such release as indicated above.

I have read and understood the terms of this Authorization and I have had a chance to ask questions about the use or disclosure of my health information. I authorize the named entity above (page 1) to use or disclose my health information in the manner described above.

X _____ _____ ☐ AM ☐ PM

Patient Signature **Date / Time**

_____ _____

Legal Representative Signature **Relationship to patient**

_____ _____ ☐ AM ☐ PM

Behavioral Health Clinician Signature **Date / Time**

ARIZONA RESIDENTS

The information authorized for release may include records concerning a communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and HIV/AIDS. You may have additional protections under Arizona Revised Statutes 36-664 if this type of information is to be released.