Adam Vellturo MSW; LCSW Counseling Services

CONSENT TO TREAT AND USE/DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____ and me, Adam Vellturo, MSW, LCSW. When I use the word "you" below, it can mean you, your child, a relative or other person if you have written his/her name here:_____.

When I evaluate, test, diagnose, treat, or refer you, I will be collecting what the law calls Protected Healthcare Information (PHI) about you. I need to use this information here to decide on what treatment is best for you and to provide any treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this Consent Form, you are acknowledging that you have read my State of Arizona Psychotherapist-Patient Services Agreement and my Arizona Notice of Privacy Practices (ANPP) and you understand and are agreeing with what you have read. You are also agreeing to let me treat you and use your information here and send it to others if necessary. The ANPP explains more in detail your rights and how I can use and share your information.

If you do not sign this Consent Form agreeing to what is in my Arizona Notice of Privacy Practices, I cannot treat you.

In the future, I may change how I use and share your information and so may change my ANPP. If I do change it, you can obtain a copy from me.
If you are concerned about some of your inform.

If you are concerned about some of your information, you have the right to ask me not to use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if we do agree, I promise to do as you asked.

After you have signed this Consent Form, you have the right to revoke it (by writing a letter to me telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on, but I may have used or shared some of your information and cannot change that.

_____ Date: ____/____/____
Signature of client or his/her personal representative

_____ Relationship to Client:_____
Printed name of client or personal representative

_____
Description of personal representative's authority

_____
Signature of authorized representative of this practice

Date Of NPP 12/19/21 *Copy given to the client/personal representative upon request.*