Valle del Sol
COMMUNITY HEALTH

Consent for Treatment and Disclosure

I hereby grant permission to Valle Del Sol to provide routine evaluation and treatment services as may be deemed necessary or advisable for the diagnosis and/or care of Click or tap here to enter text.. I understand that this consent shall remain valid so long as I am enrolled in services or until I withdraw consent.

I understand that all information gathered in the course of my treatment at Valle Del Sol is confidential. However, confidential information may be disclosed without my consent in accordance with state and federal law. Examples of such disclosures include situations of an emergency involving a serious and imminent threat to a person or the public; the reporting of child or adult abuse or neglect; court ordered disclosures; financial claims requirements and audit and program evaluations. I understand that for purposes of my treatment, my treatment information may be discussed by other members of my Clinical Team, and other professionals at Valle Del Sol. Additionally, I understand that by signing this consent I am giving permission for ADHS/DBHS, BMFL, the RBHA, PCPs and other external health entities to access my information and records maintained by Valle Del Sol and/or its subcontracted providers concerning the provision of covered services.

I understand that in addition to the above-mentioned disclosure, Valle Del Sol may disclose without my consent reported animal abuse, cruelty, or neglect to the proper authorities.

I understand that the philosophy of care at Valle Del Sol includes the belief that people should be treated in the least restrictive environment and that Valle Del Sol staff do not provide any physical, mechanical, or chemical restraints. Staff are trained to intervene, when necessary, using nonphysical techniques in an attempt to calm an escalating situation, and will call the police if anyone's physical safety is at risk.

I agree to participate in my treatment planning process to the best of my ability.

By signing this form, I understand that I am giving consent to receive evaluation and treatment services from Valle Del Sol in accordance with the information described below.

Please read:

- I have and/or will provide a medical history that is true and complete to the best of my knowledge.
- I have and/or will be given information about the diagnosis and the proposed treatment.
- I have and/or will be given information about the intended outcome and all available procedures involved in the proposed treatment.
- I have and/or will be informed of any additional risks, including any side effects of the proposed treatment.
- I have and/or will be informed of the risks of not proceeding with the proposed treatment.
- I have and/or will be given information on any alternatives to the proposed treatment including those offering less risk or fewer adverse effects.
- I have and/or will be given a description of any clinical factors that might require suspension or termination of the proposed treatment.
- I understand any consent given may be withheld or withdrawn in writing or verbally at any time and will be documented in the medical record.
- I understand that if consent is revoked, treatment must be promptly discontinued, except in cases in which abrupt discontinuation of treatment may pose an immediate risk. In such cases, I understand that treatment may be phased out to avoid any harmful effects.
- I understand that all information gathered in the course of treatment is confidential and will not be disclosed without my permission except as allowed by law.

Valle del Sol
COMMUNITY HEALTH

Patient Disclaimer
Payment for services, including insurance co-payment or self-pay balance amount, is due at the time services are rendered unless payment arrangements have been approved in advance.
I understand that it is my responsibility to provide accurate and current insurance information to Valle del Sol. I will be asked to periodically update my insurance information. I understand that if I have an insurance change that it is my responsibility to notify Valle del Sol and provide a copy of my insurance card. I also understand that if services are rendered and my insurance denies my claim that I am responsible to pay those charges.

Communication Consent

The health information collected and provided by Valle Del Sol, Inc. and affiliates through its electronic means or a voice message to health care professionals, schools, caregivers, and guardians, is provided only at the consent of the client and/or guardian (if the recipient is a minor).

Valle Del Sol, Inc. and affiliates currently have a secure email system. This secure email requires username and password to access personal information, but there could be a possibility, protected health information contained in such emails may be disclosed to, or intercepted by, unauthorized third parties.

- Highly sensitive or personal information will not be communicated by voicemail, email, or text
- When using email, the information transmitted will be minimum information

Should information disclosed under this consent be disclosed to others by the recipient, it is no longer considered protected health information covered under this consent.

I, ☐ **do** / ☐ **do not** authorize Valle Del Sol and affiliates to communicate certain behavioral health information via **Voicemail** to me or to a third-party for coordination of care. I understand that I have the right to revoke this authorization at any time but must do so in writing. I understand that the revocation will not apply to information that has already been related in response to this authorization. This authorization will terminate on the date services have ended with Valle Del Sol and affiliates.

I, ☐ **do** / ☐ **do not** authorize Valle Del Sol and affiliates to communicate certain behavioral health information via **email** to me or to a third-party for coordination of care. I understand that I have the right to revoke this authorization at any time but must do so in writing. I understand that the revocation will not apply to information that has already been related in response to this authorization. This authorization will terminate on the date services have ended with Valle Del Sol and affiliates.

I, ☐ **do** / ☐ **do not** authorize Valle Del Sol and affiliates to communicate certain behavioral health information via **Text** to me or to a third-party for coordination of care. I understand that I have the right to revoke this authorization at any time but must do so in writing. I understand that the revocation will not apply to information that has already been related in response to this authorization. This authorization will terminate on the date services have ended with Valle Del Sol and affiliates.

Valle del Sol
COMMUNITY HEALTH

Informed Consent to Participation in Telemedicine Services
Record Participation

I, Click or tap here to enter text., have been offered health services via telemedicine. I have been informed of my diagnosis and proposed telemedicine treatment plan. I understand that I will be receiving health care services through interactive videoconferencing equipment. I understand that, at this time, there are no known risks involved with receiving my care in this way.

I understand that the equipment will be shown to me, and I will see how it works before I receive any services. I understand that my participation in telemedicine is voluntary, and I may refuse to participate or decide to stop participation at any time. I understand that my refusal to participate or decision to stop participation will be documented in my medical record. I have been informed of the potential consequences of my revocation of informed consent to treatment.

I understand that my privacy and confidentiality will be protected. I also understand that the likelihood of a videoconference being intercepted by an outsider is similar to the potential interception of a phone call. When I am receiving services via telemedicine, I will be notified as to who is in the room at the remote site.

I understand that the services I receive via telemedicine will be recorded and viewed by other persons for a specific clinical or educational purpose. I understand that the use of the videotape recording is for the following purpose:

I understand that I have the right to rescind permission to use the videotape at any time. I understand that permission to use the recording will become void on the date indicated in the box checked below unless I renew permission to use it.

I understand that the health care providers at both my location and the remote video site will have access to any relevant medical information about me including any psychiatric and/or psychological information, alcohol and/or drug abuse, and mental health records. **I understand that, if I am receiving services related to alcohol and other drugs or HIV status, no material, including video recordings, may be re-disclosed unless further disclosure is expressly permitted by me under 42 CFR Part 2 or A.R.S. 36-664.**
I have read this document and I hereby consent to participate in receiving health services via telemedicine under the terms described above. I understand this document will become a part of my medical record.

☐ **I understand that these clinical sessions will be recorded. I understand that the permission I grant here to use the recording will become void in 1 year unless I renew the permission in writing at that time.**

☐ **I do not want my telemedicine services to be recorded at this time**

Valle del Sol
COMMUNITY HEALTH

Valle del Sol Transportation Agreement

I am currently enrolled in services at Valle del Sol and am receiving a 1-day bus pass due to not being able to get to services any other way. I acknowledge that receiving this is a privilege and I will treat it as such.

- I will return my previous day's bus pass prior to receiving another one.
- I will not keep bus passes at my home if I have not used them; I will return them to the clinic.
- I will not sell my bus passes to anyone - they will be used for transportation purposed by me only
- I will not buy bus passes from other VDS patients

I also understand that any violations of the above-mentioned items may be grounds for immediate loss of bus pass privileges and that the clinical team will determine when and if it is appropriate for me to gain these privileges again.

I also understand that any misuse of these passes is illegal and may results in the following violations:

12-2316.01 Unlawful possession of access device
12-2310 Fraudulent schemes and artifices
13-2307 Trafficking in stolen property

Informed Consent to Participate in Telemedicine Services Health

I, Click or tap here to enter text., have been asked to receive health services via telemedicine. I have been informed of my diagnosis and proposed telemedicine treatment plan. I understand that I will be receiving health care services through interactive videoconferencing equipment. I understand that, at this time, there are no known risks involved with receiving my care in this way.

I understand that the equipment will be shown to me, and I will see how it works before I receive any services. I understand that my participation in telemedicine is voluntary, and I may refuse to participate or decide to stop participation at any time, verbally or in writing. I understand that my refusal to participate or decision to stop participation will be documented in my medical record. I have been informed of the potential consequences of my revocation of informed consent to treatment.

I understand that my privacy and confidentiality will be protected. I also understand that the likelihood of a videoconference being intercepted by an outsider is similar to the potential interception of a phone call. When I am receiving services via telemedicine, I will be notified as to who is in the room at the remote site.

I understand that the health care providers at both my location and the remote video site will have access to any relevant medical information about me including any psychiatric and/or psychological information, alcohol and/or drug abuse, and mental health records.

I have read this document and I hereby consent to participate in receiving health services via telemedicine under the terms described above. I understand this document will become a part of my medical record.

☐ **I agree to participate in and receive health services via telemedicine.**

☐ **I decline to participate in and receive health services via telemedicine.**

Valle del Sol
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Welcome to our Patient Portal

Our staff wish to welcome you to the Patient Portal at Valle del Sol! The Patient Portal will provide you and your family with:

- A secure method of communication between you and the medical provider or medical assistant
- A simpler and more effective way to request medication refills
- The ability to update your contact and other important information online
- Requested appointments with your medical provider online

The Patient Portal at Valle del Sol is another way that you can take charge of your personal healthcare. If you are interested in utilizing this feature, please place your email address in the space below and the medical assistant and your providers will give you more information how to access the Patient Portal. If you are not interested, please leave this form blank.

Email: _____

Please sign and complete the information below if you would like to access the Patient Portal.

I, _____ (Parent/Guardian/Self), **agree to the usage of the Patient Portal** to enhance the communication process between Valle del Sol, Inc., and myself. Further, I understand the Patient Portal is certified HIPAA security compliant and that the Patient Portal is not to be used to communicate in an emergency. If I have an emergency issue, I will call 911 or go to the emergency room for care.

Please Print Patient Information:

Name: _____
First **M** **Last**

Date of Birth: _____

☐ I am not interested in Patient Portal at this time

Valle del Sol
COMMUNITY HEALTH

healthcurrent

Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?
In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current?
The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared?
People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning and population health services. You may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form.
Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.
The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

Valle del Sol
COMMUNITY HEALTH

Does Health Current receive behavioral health information and if so, who can access it?
Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from federally assisted substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share the substance abuse treatment records it receives from these programs in two cases.
One, medical personnel may access this information in a medical emergency.
Two, you may sign a consent form giving your healthcare provider or others access to this information.
How is your health information protected?
Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing You have the right to:
1. Ask for a copy of your health information that is available through Health Current. Contact your healthcare provider and you can get a copy within 30 days.

2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.

3. Ask for a list of people who have viewed your information through Health Current. Contact your healthcare provider and you can get a copy within 30 days. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 3, section 3802 to keep your health information from being shared electronically through Health Current:
1. You may "opt out" of having your information available for sharing through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. After you submit the form, your information will not be available for sharing through Health Current.

Caution: If you opt out, your health information will NOT be available to your healthcare providers even in an emergency.
2. You may exclude some information from being shared. For example, if you see a doctor and you do not want that information shared with others, you can prevent it. On the Opt Out Form, fill in the name of the healthcare provider for the information that you do not want shared with others.

Caution: If that healthcare provider works for an organization (like a hospital or a group of physicians), all your information from that hospital or group of physicians may be blocked from view.

3. If you opt out today, you can change your mind at any time by completing an Opt Back In Form that you can obtain from your healthcare provider.

4. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.

Valle del Sol
COMMUNITY HEALTH

Health Current (Contexture)
2901 N. Central Ave., Ste. 1100
Phoenix, AZ 85012
Phone: 844-279-7120Email: hello@contexture.org

Patient Information

Patient Name:	
Date of Birth:	
Medical Record Number (MRN):	

Participation Options

Please select one option:

☐ I CONSENT to participate in Health Current (HIE).
I understand that my health information will be shared with other healthcare providers participating in Health Current to support my treatment, care coordination, and services.

☐ I DECLINE to participate in Health Current (HIE).
I understand that my health information will not be shared through Health Current except as otherwise permitted or required by law. I reserve the right to change my decision at any time by submitting a new form.

Acknowledgment

I understand the information above and the implications of my choice.

Patient Signature: _____ Date: ___ / ___ / _____

Parent/Guardian/Surrogate Signature (if applicable): _____ Date: ___ / ___ / _____

Witness/Staff Signature: _____ Date: ___ / ___ / _____

For Valle del Sol Use Only

Reviewed by: _____

Date Entered into EHR: ___ / ___ / _____

Documentation Verified: ☐ Yes ☐ No

Compliance Note: This form documents the patient's choice to participate or decline in Health Current (Arizona's HIE) in accordance with ADHS Title 36, HRSA program requirements, and Joint Commission standards on patient rights and informed consent. A copy must be maintained in the patient's medical record.

Valle del Sol
COMMUNITY HEALTH

What is an Advance Directive?

An Advance Directive is a legal document that allows you to express your preferences regarding medical care if you are unable to communicate your wishes. It lets your doctors and loved ones know what kind of medical treatment you would or would not want.

An Advance Directive may include:
- Living Will – Describes the medical treatments you do or do not want at the end of life.
- Durable Power of Attorney for Health Care (Healthcare Proxy) – Names a person you trust to make health care decisions for you if you cannot.
- Mental Health Care Power of Attorney – Names a person you trust to make mental health care decisions if you are unable to do so.

These documents are recognized under Arizona law and by federal regulations. They help ensure that your wishes are honored and reduce stress on your family and healthcare team.

Why is an Advance Directive important:
- Ensures your treatment choices are known and respected.
- Helps guide your loved ones and providers during medical emergencies.
- Gives you control of your health care decisions even when you cannot speak for yourself.

Helpful Links and Resources:
- Arizona Attorney General – Advance Directive Registry:
https://www.azag.gov/seniors/life-care-planning
- Arizona Advance Directive Forms (Arizona Health Care Directives Registry):
https://azhdr.org/
- National Hospice and Palliative Care Organization – Caring Info Advance Directive Forms:

https://www.caringinfo.org/planning/advance-directives/
• AARP Advance Directive Resources: https://www.aarp.org/caregiving/financial-legal/free-printable-advance-directives/
• U.S. Department of Health & Human Services – Advance Care Planning: https://www.medicare.gov/manage-your-health/advance-directives/advance-directives-and-long-term-care

Patient Acknowledgement:
I acknowledge that I have received information about Advance Directives, including what they are, why they are essential, and where to find additional resources.

Patient Name: _____ Date: ___/___/_____

Signature: _____ Date: ___/___/_____

Staff Name/Title: _____ Date: ___/___/_____

Staff Signature: _____ Date: ___/___/_____

Valle del Sol
COMMUNITY HEALTH

RECEIPT OF INFORMATION

By signing below, I acknowledge that I have received and reviewed the following documents from Valle del Sol Community Health:

1. i. Consent for Treatment and Disclosure
2. ii. Communication Consent
3. iii. Telemedicine Participation Consent
4. iv. Transportation Agreement
5. v. Patient Portal Registration
6. vi. Notice of Health Information Practices
7. vii. Patient Rights Procedure
8. viii. Patient Complaint/Grievance Procedure
9. ix. Advance Directives Form
10. x. Patient Surrogate/Guardian Identification Form
11. xi. Language Assistance Request Form

Patient Signature: _____ Date: ____/____/_____

Witness/Staff Signature: _____ Date: ____/____/_____

This form serves as documentation that the patient received the listed information in compliance with HRSA, ADHS, and Joint Commission standards regarding patient rights, privacy, and informed consent.