Neighborhood Outreach Access to Health

NOAH Behavioral Health

General Consent to Treat

I authorize NOAH Behavioral Health to provide evaluation and treatment services to:

_____	_____
Patient Name (Print)	Date of Birth

I agree to participate in my treatment planning process to the best of my ability and will let my provider know if situations occur that prevent me from participating in treatment. Furthermore, my provider explained the benefits and risks of therapy; adverse effects from therapy; risks of not receiving treatment; and alternative treatment options.

I understand that this consent will remain valid as long as I am a client of NOAH Behavioral Health or until I withdraw consent.

I understand that by signing this consent form, I am giving permission to the Arizona Department of Health Services/Bureau of Medical Facilities Licensing and all members of my clinical treatment team to access my information and records. I understand that all of the information gathered in the course of my treatment is confidential. However, confidential information may be disclosed without my consent in accordance with state and federal law.

_____	_____
Patient Signature	Date
_____	_____
Parent/Legal Guardian	Date
_____	_____
Parent/Legal Guardian	Date
_____	_____
Staff Member (Witness)	Date