



**University of Nevada, Reno**  
Counseling Services

**Your Personal Mental Health Information Rights (PMHI)**

**Please read, complete, and sign this form:**

I am requesting psychological evaluation and/or treatment at Counseling Services.

**You have the right to:**

- State verbally or in writing how you prefer to be contacted by our staff, in order to protect your privacy.
- Inspect your file in the presence of a counselor on our staff. You may also request, in writing, a copy of your file, although you may be required to pay postage and copying costs.
- Request further restriction on the uses and disclosures of your PMHI. Such a request must be in writing (or via a form available at the Front Desk). We are not required to agree to your request, and encourage you to discuss any confidentiality concerns with your counselor or the Director. Once we have agreed to further restrict use or disclosure of your record, we will comply with this request unless the information is needed to provide you with emergency treatment.
- Request, in writing, an amendment or clarification of your record. If you believe that the information in your record is inaccurate or incomplete, you can make a Request for Amendment to the Director, who will respond, in most cases within 30 days. We are not required to accept your request, but will note in the record that it has been made.
- Obtain an accounting of disclosures of your PMHI, except that we are not required to account for disclosures pursuant to authorization or consultation within this office.

**Consent for Counseling**

**I understand the following:**

- Counseling Services offers short term and/or intermittent individual, couple, and group psychotherapy, as well as referrals to other campus or community agencies. These treatment options will be discussed with me at my intake session, or at other appropriate points in the psychotherapy process, to determine the type of service that will best meet my needs. If my needs cannot be reasonably met by this office, I will be referred to other appropriate service providers.
- I am expected to participate in my appointments and treatment planning.
- Any cancellation of scheduled appointments should be made at least 24 hours in advance, and, should I miss two consecutive appointments without cancelling, this may be grounds for services to be discontinued.
- I may be asked to complete follow-up questionnaires after my counseling is terminated. This questionnaire is designed to give feedback to Counseling Services for their on-going evaluation of their services.
- Counseling Services, as part of a teaching institution, is a professional counselor/ psychologist training site, and my counselor may be an advanced graduate trainee under licensed professional supervision. Should this be the case, I understand that any meeting I have with my counselor may be confidentially reviewed with my counselor's supervisor, or other professional consultants within the office of Counseling Services.

- Every effort will be made to keep the results of each evaluation or treatment strictly confidential, as provided by law. Information concerning me, specifically, will not be released outside of Counseling Services except to agencies or individuals I designate in writing, with the exception of those situations described in the Notice of Privacy Practices.
- I have the right to revoke any authorization that I have given for future release of information.
- Contacts with me for follow up or continued service will be made in keeping with the directions I've provided on my intake papers.
- No information about sessions involving more than one person, such as couples or group therapy, can be released to others without the written consent of each participant.
- If I am under age 18, I must have the signature and consent of a parent or legal guardian (appointed by a court of law) before any general treatment may begin, and such consent must be effective until I reach legal age in the State of Nevada (18 years old). My parent or legal guardian must also receive a Notice of Privacy Practices.
- Aggregate information from my intake and follow-up questionnaires may be used for research purposes with the understanding that neither my name nor other individually identifiable data will ever be used for such a purpose.

*Exemptions to this consent may be granted under NRS 129.030 for a life-threatening emergency or a serious health hazard, or in other situations as specified in the statute where I have been living apart from parents; treatment for emancipated minors with court supporting documents.*

**I understand that the Notice of Privacy Practices that has been provided to me describes in full how my health information is protected and confidential, and that it further describes those circumstances in which that information may be disclosed by Counseling Services and how I can get access to that information, if I should wish to do so.**

These matters having now been explained to me, I fully and freely give my consent. If I have questions or concerns I may contact the Counseling Services' Director at 784-4648. I understand that I may withdraw from treatment at any time.

Signature of Client: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Client (*print name*): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Counselor: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**If client is a minor, please complete information below**

Client's Representative Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name: \_\_\_\_\_

Description of Legal Guardianship: \_\_\_\_\_

Phone Number: \_\_\_\_\_