3067 E. Warm Spring Rd., Ste. 100
Las Vegas, NV 89120
O: 702.202.0000
F: 702.710.6521

CONSENT FOR ASSESSMENT

CLIENT NAME: _____ **DATE OF BIRTH:** _____ (Last) (First) (MI) (Month/Day/Year)

I, _____ authorize Odyssey Wellness, and staff (subsequently complete a disability evaluation for myself in order to provide information on my behalf with Vocational Rehabilitation, to process my claim._____ **(your initials)**

I understand that the information given to the Provider is not confidential and will be utilized for a report that will be submitted to Vocational Rehabilitation. I understand that the Provider does not make any decisions regarding compensation and benefits. All decisions will be made by Vocational Rehabilitation. _____ **(your initials)**

I understand that most information disclosed to the Provider is protected by federal and state regulations governing confidentiality and cannot be disclosed to others without my consent. I understand that due to the Nevada State Regulations, there are legal exceptions in which my consent is not necessary to disclose information to others, including:

> In cases of past or present suspected child abuse or neglect, a report must be made to Child Protective Services no later than 24 hours after the information is revealed. In cases of abuse or neglect of a person older than 60 or of a disabled person or legally incompetent person, a report must be made to local law enforcement agencies. In cases where a client is in imminent risk of harming self or others, or when a person with mental illness needs hospitalization, confidentiality may be suspended for the protection of self and/or treatment of mental illness. In cases when a person appears to have been injured by a knife, firearm or burn, this information must be reported to local law enforcement or local fire department officials respectively.

Confidentiality may also be necessary for determining the validity of a will; when a person is court ordered for a psychological investigation or hearing. _____ **(your initials)**

I understand that the Provider cannot provide any records. All request for records must be referred directly to Vocational Rehabilitation.
_____ **(your initials)**

_____ _____

Client Name Date

_____ _____

Signature Date