Vista Behavioral Health, LLC
152 Simsbury Road
Bldg 9, FL 2
Avon, CT 06001
(860) 269-3101
(860) 269-3102

AUTHORIZATION TO OBTAIN HEALTH INFORMATION

I, the undersigned patient or legal representative, hereby authorize ***Clinicians at Vista Behavioral Health, LLC,*** to obtain or disclose health information including, if applicable, information pertaining to the diagnosis or treatment of any condition that may impact behavioral health for:

Patient Name: ___________________________

Date of Birth: ____/____/____

This information may be obtained from the following source:

Name of Primary Care Physician: ____

Address:____

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Phone #: ____

FAX #: ____

The types of information to be disclosed are medical history and most recent physical examination results, and laboratory results, testing, and any consultation reports.

This information is to be used for the purpose of ongoing treatment and coordination of care.

This authorization will be valid for the duration of the patient's participation. I understand that under applicable Federal and State law the confidentiality of the information disclosed under this authorization prohibits the receiver from making any further disclosure of these records without specific consent of the undersigned patient or legal representative or as otherwise provided by law.

Patients under the age of 18 receiving drug abuse treatment may sign their own authorization.

____ ____________________
Signature of Patient or Legal Representative (and relationship) Date

____ ______________________
Print Name Witness