

Vista Behavioral Health Associates

1370 Washington Pike
Suite 303
Bridgeville, PA 15017
412-206-0123

Authorization to Use or Disclose Health Information

Patient Name: _____ **Date of Birth:** _____

Address: _____

I authorize _____ to release to: (Name and Address):

the following information from my treatment record:

- | | |
|-------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Summary of treatment – verbal or written | <input type="checkbox"/> Medication History |
| <input type="checkbox"/> Complete records | <input type="checkbox"/> Labs/diagnostic tests |
| <input type="checkbox"/> Psychiatric/mental health evaluation | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Other: _____ | |

including information relating to medical, mental health, drug, alcohol, and/or HIV related treatment during the following dates: _____ to _____

This information will be used for the following purpose:

- | | |
|-----------------------------------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> Continuity of care | <input type="checkbox"/> Disability determination |
| <input type="checkbox"/> Return to work | <input type="checkbox"/> Insurer’s request |
| <input type="checkbox"/> Coordinate medical & mental health treatment | <input type="checkbox"/> Coordinate academic & mental health planning |
| <input type="checkbox"/> Other: _____ | |

I understand that, unless action has already been taken as a result of this authorization, I may revoke it at any time by making a written request to Privacy Officer. This consent will terminate one (1) year from the date of the consent unless otherwise specified as follows (insert date) _____.

I understand that Vista may not make my treatment conditional on my signing an authorization unless the treatment is for the purpose of creating health information for a third party.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient of this information and no longer protected by the HIPAA Privacy Rule.

I understand I have the right to request restrictions on uses and disclosures of protected health information with my provider’s agreement. I request the following information to be restricted:

Signature of Patient or Legal Representative

Date

Signature of Witness

Date

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.