



Place of Birth (City and State):		
Connecticut Resident From:		To
Home Address:		
City:	State:	Zip Code:
Home Phone: (    )	Work Phone:	
Cell Phone: (    )	E-mail Address	
Are You Currently Living at Your Home Address? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If No, where are you staying now?		
<input type="checkbox"/> Shelter	<input type="checkbox"/> With Family/Friends	<input type="checkbox"/> Hotel/Motel <input type="checkbox"/> Temporary Veteran Housing
<input type="checkbox"/> Treatment Facility	<input type="checkbox"/> Other (Explain below)	
What is your Race? (You may check more than one. Information is required for statistical purposes only.)		
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Black or African American	
<input type="checkbox"/> Asian	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
Are you Spanish, Hispanic, or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Section 2: EMERGENCY CONTACT(S)		
Name:	Relationship:	Phone #1 (    ) Phone #2 (    )
Name:	Relationship:	Phone #1 (    ) Phone #2 (    )
Name:	Relationship:	Phone #1 (    ) Phone #2 (    )

Section 3: HEALTH INSURANCE
Are you enrolled in the VACT Healthcare system? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you covered by any other health insurance policies? <input type="checkbox"/> Yes <input type="checkbox"/> No

If so, name of Policy Holder	Group Code
Policy #	

Section 4 - MILITARY SERVICE		
Were you issued more than one (1) DD214? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please provide copies	
Do you have a VA service-connected disability rating and are receiving VA compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, what %	Amount
What condition(s) are you service connected for? (Please explain)		

Section 5 - RECOVERY	
Are you currently attending a substance abuse treatment program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Program:
Date begun:	
Substances Used:	Approximate Date of Last Use: (Month/Year)
Alcohol Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Marijuana Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Cocaine Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Hallucinogens Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Inhalants Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Opiates Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Amphetamines Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Barbiturates Y <input type="checkbox"/> N <input type="checkbox"/>	_____
PCP Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Other (specify) Y <input type="checkbox"/> N <input type="checkbox"/>	_____

Have you previously attended a program for drug or alcohol treatment?

Yes  No

If Yes, When and Where?

### Section 6 - EDUCATION

High School Graduate  Yes  No

If no, highest grade completed

GED  Yes  No

Technical School

Certificate

Some College

Associate Degree

Bachelor's Degree

Master's Degree

Are you currently enrolled in college?  Yes  No

Name of College:

Program of Study:

Are you currently enrolled in a Vocational Training program?  Yes  No

Name of School:

Program of Study:

### Section 7 - EMPLOYMENT

Are you currently employed?  Yes  No

Full-time  Part-time

Name of Employer:

Address:

City:

State:

Zip Code:

Job Title:

### Section 8 - LEGAL HISTORY

Have you ever been convicted of a felony?  Yes  No

If Yes, please complete below

Felony Charge	Date of Conviction	Town	State
Have you been arrested for any offenses that have not yet been resolved in court? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, please explain)			
Are there any outstanding warrants for your arrest? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, please explain)			
Are you currently on Probation?		If Yes, what legal charge(s) are you on Probation for?	
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Probation Officers Name:		Phone #	
Are you currently on Parole?		If Yes, what legal charge(s) are you on Parole for?	
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Parole Officers Name		Phone #	
<b>PLEASE SUBMIT A COPY OF YOUR CURRENT TERMS/CONDITIONS OF PROBATION/PAROLE</b>			

<b>Section 9 - POWER OF ATTORNEY / CONSERVATORSHIP</b>			
<b>Power of Attorney</b>			
Do You Have a Power of Attorney?	If Yes - Is this Appointment for:		Effective Date:
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Person <input type="checkbox"/> Estate <input type="checkbox"/> Both		
<b>If Yes, complete information below - enclose a copy of decree</b>			
Name:	Relationship		<input type="checkbox"/> Family Member
			<input type="checkbox"/> Friend <input type="checkbox"/> Attorney
Address:			Apt #
City:	State	Zip Code	
Phone #'s	Home Phone	Work Phone	
	Cell Phone	Fax #	
Email Address			

<b>Conservatorship</b>		
Do You Have Someone Appointed as Your Conservator? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes - Is this Appointment for: <input type="checkbox"/> Person <input type="checkbox"/> Estate <input type="checkbox"/> Both	Effective Date:
<b>If Yes, complete information below - enclose a copy of Decree</b>		
Name:	Relationship	<input type="checkbox"/> Family Member <input type="checkbox"/> Friend <input type="checkbox"/> Attorney
Street:		Apt #
City:	State	Zip Code
Phone #'s:	Home Phone	Work Phone
	Cell Phone	Fax #
Email Address:		

<b>Section 10 – MEDICAL/HEALTH</b>
Do you currently have any medical or health issues that you would like us to know about? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please identify:
Are you currently on any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please identify:
Name of medical provider (optional):

<b>Referred by</b>				
<table border="1"> <tr> <td><b>Contact Name/Title</b></td> <td></td> </tr> <tr> <td><b>Agency</b></td> <td></td> </tr> </table>	<b>Contact Name/Title</b>		<b>Agency</b>	
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**STATE OF CONNECTICUT  
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES  
VETERANS RECOVERY CENTER  
Fellowship House, Department of Veterans Affairs  
287 West Street, Rocky Hill, CT 06067  
Telephone: 860-616-3832 Fax: 860-616-3549**



**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION  
THIS IS A LEGAL DOCUMENT AND WILL NOT BE HONORED UNLESS IT IS COMPLETED IN FULL**

Client (Last Name, First Name) \_\_\_\_\_ Date of Birth \_\_\_\_\_ MPI # \_\_\_\_\_ Last 4 digits of SS# \_\_\_\_\_

**I, the undersigned, authorize the above named facility to:**  **DISCLOSE** information to  **OBTAIN** information from

Name of Person \_\_\_\_\_ Name of Organization \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

I understand that this authorization is voluntary and that information to be released/obtained may include Medical, Psychiatric, Substance Abuse and/or HIV/AIDS treatment information unless otherwise specified:

Limitations/Restrictions: \_\_\_\_\_

**Purpose of Release:**  Evaluation/Treatment  Benefit Determination  
 (Check Appropriate Boxes)  Placement/Referral  Case Management Coordination  
 Other (specify): \_\_\_\_\_

**Information to be released/obtained:** (Check Appropriate Boxes)

Psychiatric Evaluation  Medical History and Physical Exam  Diagnostic Reports (specify): \_\_\_\_\_  
 Psychosocial History/Assessment  Discharge/Transfer Summary \_\_\_\_\_  
 Psychological Evaluation  Medication Records \_\_\_\_\_  
 Treatment Plans  Other (specify): \_\_\_\_\_

**Dates of Treatment Covered by this Request:**  
 All prior episodes of care, through discharge from present episode of care  
 Limited to the following Dates(s):  
 \_\_\_\_\_

**This authorization, if not cancelled, will expire:**  
 \_\_\_\_\_  
 Date (not to exceed 12 months), event or condition upon which this authorization expires. If blank, authorization will expire 12 months from date of signature below.

I understand that refusal to sign this authorization form will in no way affect my right to obtain present and future treatment, except where disclosure of such communications and records is necessary for treatment. I also understand that I may revoke this authorization at any time by signing the "CANCELLATION/REVOCAION" section below, except to the extent that action has been taken in reliance on it. I further understand that the confidentiality of psychiatric, substance abuse and HIV/AIDS records are protected under State and Federal Laws and cannot be disclosed without my written authorization unless otherwise provided for by law. The information disclosed by this facility pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal law. I understand that this authorization is voluntary and that information to be released/obtained may include Medical, Psychiatric, Substance Abuse and/or HIV/AIDS treatment information unless otherwise specified above.

Signature of Patient/Client/Authorized (Legal) Representative\* \_\_\_\_\_ Date \_\_\_\_\_

A copy of this authorization will be provided to the Patient/Client/Authorized Representative as requested.

**CANCELLATION/REVOCAION:** \_\_\_\_\_  
 Signature of Patient/Client/Authorized (Legal) Representative\* \_\_\_\_\_ Date \_\_\_\_\_

\*If this form has been signed by the patient's/client's Authorized (Legal) Representative, a copy of the legal appointment must be attached.  Conservator/Guardian  Executor of Estate  Other (specify): \_\_\_\_\_

**NOTE: Confidentiality of psychiatric, drug and/or alcohol abuse and HIV records is required and no information from these specific records shall be transmitted to anyone else without written consent or authorization as provided under Connecticut General Statutes, Chapters 899c and 368x and Federal Regulations 42 CFR 2. These laws prohibit you from making any further disclosure without specific written consent of the person to whom it pertains. A general authorization for the release of information is NOT sufficient for this purpose.**