

***Release of Information***

The purpose of this form is to authorize the parties indicated to disclose and exchange client information to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services with Chrysalis Center clinicians. The original of this form will be placed in your record and a copy may be sent to other parties.

I, \_\_\_\_\_ (client name), authorize the Chrysalis Center clinicians or administrative staff to exchange the specified information for the purpose of coordinating care. I understand that:

- I have the right to be told and to review the information being exchanged.
- Information may be exchanged via phone, fax, email or in person.
- This information will only be disclosed to parties specifically indicated, at which time those parties are responsible for maintaining the privacy of your information. Please be aware that if this information is disclosed to the court it may be made part of the court record and therefore available to the public by federal and state law.
- I may refuse or revoke my consent at any time by writing a letter to Chrysalis Center. I understand that the revocation will not apply to any information already used or disclosed under this authorization.
- This consent will be valid for one year following conclusion of treatment at Chrysalis Center, unless otherwise indicated.
- I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the Chrysalis Center, nor will it affect my eligibility for benefits.
- For further information regarding privacy practices, please see you "Rights and Consent to Treatment" and "Notice of Privacy Practices" given to you at the time of intake.

**Company/Individual Name**

**Phone/Fax/Address**

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**The following information may be shared:** (check all that apply)

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| <input type="checkbox"/> Attendance (including cancellations)   | <input type="checkbox"/> Progress or similar notes  |
| <input type="checkbox"/> Billing records  | <input type="checkbox"/> Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries |
| <input type="checkbox"/> Diagnosis(es) (current and/or past)  | <input type="checkbox"/> Recommendations  |
| <input type="checkbox"/> Discharge Notes/Summaries  | <input type="checkbox"/> Testing records  |
| <input type="checkbox"/> Evaluations and reports of consultants   | <input type="checkbox"/> Treatment, recovery, rehabilitation, aftercare plans and other similar plans                 |
| <input type="checkbox"/> Information about how the patient's condition(s) affects or has affected his or her ability to work, and to complete tasks or activities of daily living | <input type="checkbox"/> Complete copy of the medical record  |
| <input type="checkbox"/> Intake Notes and/or bio-psycho-social history  | <input type="checkbox"/> Psychotherapy notes/records  |
| <input type="checkbox"/> Medications (current and/or past)  |   |
| <input type="checkbox"/> Nutrition Records  |   |
| <input type="checkbox"/> Other: _____   |   |

Signature: \_\_\_\_\_  
 (of client or representative)

Date: \_\_\_\_\_

for:

Name (print): \_\_\_\_\_  
 & relationship to client (if representative)

Date of Birth: \_\_\_\_\_