Chrysalis Development Solutions, P.L.L.C.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED INFORMATION

Client Name: _____ DOB: _____

Record Number: _____

Consent for Release/ Exchange of Client Information

I _____hereby authorize_____
(Client or Legal Representative)
_____ to release and/or exchange specified health information to:

_____
(Recipient Name/Address/Phone/Fax)

This information shall include (client or LRP to check data to be released):

☐ Psychological Evaluation	☐ HIV*
☐ Psychiatric Evaluation	☐ Alcohol/Drug Treatment*
☐ Progress Notes from _____ to _____	☐ STD
☐ Intake Assessment	☐ Hepatitis
☐ Diagnosis	☐ Tuberculosis
☐ Treatment/Service Plan	☐ Medication Information
☐ Education Information (IEP's, educational evaluations, etc.)	☐ Medical Records
☐ Screening/Contact Assessment Form	☐ Financial/Reimbursement
☐ School Behavioral Reports	☐ Appointment Reminders
☐ Other Disclosures made regarding:	

I understand this information will be used for: ☐Continuity of Care ☐ Referral and Evaluation ☐ Case Management ☐ Service Delivery
☐Other: _____

Information to be released: ☐Verbally ☐ In Writing ☐By Fax

If not revoked earlier, this authorization expires automatically upon _____ (date or event that relates to the purpose of the use or disclosure), or one year from the date is it signed, whichever is earlier.

I hereby acknowledge that the provider has not conditioned my treatment on signing this authorization and that I may refuse to sign this authorization if I so desire. I also recognize that I retain the right to revoke this authorization except to the extent that the agency has already taken action in reliance on the consent. Request for revocation should be submitted to my treating clinician. Once information is disclosed pursuant to this signed authorization, I understand that the HIPAA privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information, and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. Upon disclosure of mental health and developmental disabilities information protected by state law (G.S. 122-C) or substance abuse treatment information protected by federal law (45 C.F.R. Part 2), this organization informs the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws.

NOTE: This authorization may include disclosure of information relating to alcohol and drug treatment, and confidential HIV/AIDS related information only if I place my initials on the appropriate line referencing these items.

_____ _____ _____
Signature of Client Date Witness-If required

_____ _____ _____
Signature of Legal Representative Date Legal Representative Relationship/Authority

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____ signed
(Name of Client)
by _____ on _____ be rescinded, effective
(Name of Person who signed authorization) (Date of signature)

_____. I understand that any action taken on this authorization prior to the rescinded date is a legal and binding.
(Effective date)

_____ _____ _____ _____
(Signature of Client) (Date) (Signature of Legal Guardian) (Date)

_____ _____
(Signature of Company Staff) (Date)

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