CHRYSALIS HEALTH
www.chrysalishealth.com

**Client Name:** _____
**Date of Birth:** _____


# CONSENT TO RELEASE AND/OR OBTAIN PROTECTED HEALTH INFORMATION (PHI)

I understand that as part of my treatment and/or services, Chrysalis Health originates, records and maintains health information and opinions about me describing my health history, symptoms, examination and test results, diagnosis, treatment/services and plans for future care ("Protected Health Information" or "PHI").

I understand that my medical information ("PHI") about my condition, treatment and/or services, which includes **mental health and/or substance abuse/use content**, cannot be disclosed beyond myself without **written consent** per Federal and State regulations including, but not limited to: Health Insurance Portability and Accountability Act of 1996 (HIPAA), Code of Federal Regulations (CFR) Title 42 Part 2-Confidentiality of Alcohol and Drug Abuse Patient Records and Title 45 Parts 160, 162 and 164-Security and Privacy, unless otherwise provided and only to such extent found in the referenced regulations.

With that understanding and for the purposes of guiding, planning and providing treatment and/or services, **I hereby give Chrysalis Health Consent to Release Information to, or Obtain Information from, the following person/agency:**

**Name:**_____ **Relation or Agency:** _____

**Address/Phone:** _____

**Regarding Client Name:** _____ **DOB:**_____

**For the purpose of (check all that apply):**

□ **Evaluation &/or Treatment Planning** □ **Medical Evaluation &Treatment** □ **Compliance with court order/subpoena**
□ **Psychiatric Evaluation & Treatment** □ **Coordination of Care** □ **Other:** _____

| PROTECTED HEALTH INFORMATION | TO BE RELEASED TO PERSON/AGENCY | TO BE OBTAINED FROM PERSON/AGENCY |
|---|---|---|
| **Verbal Communication re: Treatment/Services Provided and Progress** | | |
| **Brief Behavioral Health Status Exam/Initial Assessment** | | |
| **Bio-Psychosocial Assessment** | | |
| **Psychological Evaluations** | | |
| **Psychiatric Evaluations/Updates** | | |
| **Treatment/Service Plans and Reviews** | | |
| **Summary of Treatment/Service Progress** | | |
| **Discharge Summaries** | | |
| **Urine Analysis** | | |
| **Other:** | | |
| **Other:** | | |

I am aware that I can limit my consent to specific parties or specific information or specific uses. I also understand that Chrysalis Health has the right to refuse to provide me with treatment/services if it disagrees with any limitations I, or my legal guardian, place on uses or disclosures of my PHI. With that understanding, any **limitations to my consent are as followed:** _____
_____

Further, I understand that I may revoke my consent **in writing** at any time to the extent that Chrysalis Health has not already taken action in reliance thereon. When and if revoking my consent, I agree to send the writing to the attention of "Privacy Officer". Finally, I agree that I have been given a copy of Chrysalis Health's Privacy Notice and that I have had an opportunity to review and understand such notice before providing my consent to the terms of this agreement.

This consent is granted for: _____ A single (one-time) disclosure, expires within 90 days of the date of signing.
_____ Continuing disclosure for the purpose of care coordination, expiring 12 months from the date signed below or upon termination of treatment/services, whichever comes first.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Client Signature | Print Name | Date |
| _____ | _____ | _____ |
| Legal Guardian Signature-if applicable | Print Name | Date |
| _____ | _____ | _____ |
| Chrysalis Staff Signature | Print Name | Date |