



3904 Oleander Drive ▪ Suite 101 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

**Release/Request for 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; you may also request a copy of this form.

I, Name (print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

authorize the **Chrysalis Center clinicians or administrative staff** to use or disclose the following information. (check all that apply)

- Attendance
- Billing records.
- Diagnosis(es) (current and/or past)
- Discharge Notes/Summaries
- Lab records
- Medical notes/records
- Medications (current and/or past)
- Nutrition Records
- Intake Notes or bio-psycho-social history (may include social, family, educational, medical, and vocational histories)
- Treatment, recovery, rehabilitation, aftercare plans and other similar plans.
- Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents
- Inpatient or outpatient treatment records for physical and or psychological, psychiatric, or emotional illness
- Social work assessments, occupational therapy and vocational reports and evaluations.
- Evaluations and reports of consultants
- 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
- Academic and educational records, including achievement and other tests' results, reports of teachers' observations, and all other school or special education documents
- HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here:  Do not release these.
- Other: \_\_\_\_\_

Dates of care included: From \_\_\_\_\_ to \_\_\_\_\_ and  
From \_\_\_\_\_ to \_\_\_\_\_ and  
From \_\_\_\_\_ to \_\_\_\_\_

To this person or organization

**Company/Individual Name**

**Phone/Fax/Address**

---

---

---

I understand that:

- I have the right to be told and to review the information being exchanged.
- Information may be exchanged via phone, fax, or email.
- This information will only be disclosed to parties specifically indicated, at which time those parties are responsible for maintaining the privacy of your information.
- 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 revoked in writing by the client.
- 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 (and available for review at [www.chrysaliscenter-nc.com](http://www.chrysaliscenter-nc.com)).
- 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.
- I understand that I may review the health information described in this authorization with my clinician before it is sent. There may be a cost for this copy or other services.  Does not apply
- I understand that the professional or facility above will receive compensation for the use or disclosure of my health information The arrangement has been explained to me and I understand and accept it.  Does not apply
- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

**I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.**

\_\_\_\_\_  
Signature of client or his or her personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client or personal representative

\_\_\_\_\_  
Relationship to the client

\_\_\_\_\_  
Description of personal representative’s authority

I, a mental health professional, have discussed the issues above with the client and/or his personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

\_\_\_\_\_  
Signature of professional

\_\_\_\_\_  
Printed name of professional

\_\_\_\_\_  
Date