The Chrysalis Center
7821 N Dale Mabry Hwy, Ste 204
Tampa, FL 33614
(813) 443-4827, fax (813) 433-5459

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, The Chrysalis Center 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 The Chrysalis Center Consent to Release Information to, or Obtain Information from, the following person/agency:**

Relation or Agency: ____ Name:____

Address/Phone: ____

Regarding Client Name: ____ Client's 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	MARK TO PERMIT TO RELEASE	MARK TO PERMIT TO OBTAIN
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 The Chrysalis Center 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 follows**:

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Further, I understand that I may revoke my consent **in writing** at any time to the extent that The Chrysalis Center 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 The Chrysalis Center'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