CHRYSALIS RECOVERY CENTER, LLC / CRC-IDCMP

Main Office and Mailing for ALL locations
112 S. State St. Concord, NH 003301

Satellite Offices:
15 High St. Manchester, NH 03101
20 Canal St. Franklin, NH 03235
1130 1st NH Turnpike Northwood, NH 03261

Phone (603) 998-4210 ♦ Fax (603) 532-0720

Transforming Lives...

Instructions: initial all lines with initials signature and complete for person you want us to be able to speak to

I, _____, authorize: Chrysalis Recovery Center, LLC_
Print client name — Program or Agency

Please Initial: _____ to disclose to, AND _____ to receive from (person/agency) _____

Address (of person/agency) _____

Phone (of person /agency): _____fax (of person /agency):_____

Email of person/agency:_____

the following information (PLEASE INITIAL ALL LINES)

_____	My identity as a client	_____	Psychological or Psychiatric Evaluation
_____	Initial Contact Date / Intake Completed Date	_____	Substance Use Evaluation
_____	Intake Summary / Assessment	_____	Anger Management / DV Evaluation
_____	Attendance / Non-Attendance	_____	Substance Use/Abuse History
_____	Progress Notes	_____	Social / Family History
_____	Participation / Compliance in Treatment	_____	History of Medical Treatment
_____	Results of Urinalysis, Blood and Breath Test	_____	History of Psychiatric Treatment
_____	Fees Owed / Outstanding Balances	___	Medications and Medication History
_____	Legal History	_____	Diagnostic Summary and Diagnoses
_____	Treatment Plan and Recommendations	_____	Discharge Summary / Prognosis
_____	Other: _____	_____	Verbal Exchange of Information
_____	Information Exchange by Email	_____	Information Exchange by Fax

_____ I understand that the information released may include information pertaining to substance abuse/dependency.

_____ I understand that the information released may include information pertaining to Hepatitis C, HIV, or AIDS.

The purpose of the disclosure authorized in this consent is:

_____

I understand that my alcohol and drug treatment records, as well as behavioral health records to be disclosed are protected by Federal Confidentiality Rules (42 CFR Part 2) and HIPPA (45 CFR Part 160 & 164). Federal Rules Prohibit any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as other permitted by 42 CRF Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This consent is subject to revocation at any time except to the extent that the program which is to make disclosure that has already been taken action in reliance on it. If not previously revoked, this consent will terminate 5 years from the date below.

I understand the risks to confidentiality involved in transmission by e-mail and fax and I agree to assume those risks. I have read this release and understand its contents.

_____ _____ _____

Client Signature DOB Date

Revised 5/2018