CHRYSALIS HEALTH REFERRAL FORM

Has client been hospitalized in past 7 days: □Yes □No Programs interested in receiving: □Outpatient □TCM

Client's first name: _____ Last name: _____

DOB: _____ SSN: _____ Gender: _____

_____

Address (on line above) City State Zip County

Best phone: _____ Phone 2: _____ Phone 3: _____

Legal guardian: _____ Relationship to client: _____

_____

Address if different from client (on line above) City State Zip County

Legal guardian's best phone: _____ Phone 2: _____

Other contact person: _____ Relationship to Referred: _____

Other contact best phone: _____ Phone 2: _____

Emergency contact: _____ Emergency contact phone: _____

Group/foster home: _____ CM: _____ Phone: _____

If client is currently receiving therapy, with whom: _____

Preferred language for client and family: _____ For whom: □Client □Family member □Other

If client visually or hearing impaired, which: _____ Auxiliary aids desired: _____

Race:	□ White	□ Black/ African American
□ Multi-Racial	□ Alaska Native	□ American Indian
□ Asian	□ Hawaiian/ Pacific Islander	□ White European

Ethnicity:	□ Cuban	□ Haitian
□ Mexican	□ Mexican American	□ Other Hispanic
□ Puerto Rican	□ Spanish Latino	□ None of the above

Where to receive services: □Home □School □Office School name: _____

Insurance/Funding: _____ ID #: _____

Names of other referred household members: _____

Name/Title of referral source: _____ Phone: _____

Email: _____ Agency: _____

Reason for referral:_____

How did you hear about us: _____

Please send completed Referral Form to Chrysalis Health via Fax: (813) 443-4828
Or Email: referrals-north@chrysalishealth.com
Website: https:\\www.ChrysalisHealth.com
For questions call (813) 443-4827

The Chrysalis Center
7821 N Dale Mabry Hwy, Ste 204
Tampa, FL 33614
(813) 443-4827, fax (813) 443-4828

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:**

Name:_____ Relation or Agency: _____

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	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 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:**

_____

_____

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

Chrysalis Health Location Information

HILLSBOROUGH	ORANGE	PINELLAS
Administration & Clinical Departments 7821 N Dale Mabry Hwy Suite 204 Tampa, Florida 33614 T: 813-443-4827 F: 813-443-4828	Administration & Clinical Departments 1703 West Colonial Dr Orlando, Florida 32804 T: 407-219-9304 F: 407-264-6333 Targeted Case Management 6000 Rio Grande Ste 103 Orlando, Fl 32809	Phone line only T: 727-231-4885 F: 727-255-5683 **PASCO** Phone line only T: 352-205-4788 F: 352-397-4466
DUVAL Administration and Outpatient Department 2121 Corporate Sq Blvd Suite 124 Jacksonville, Florida 32216 T: 904-207-7073 F: 904-485-8970	**VOLUSIA** Outpatient Department 412 South Palmetto Avenue Daytona Beach, Florida 32114 T: 386-254-2848 F: 386-254-2847	**OCALA** Outpatient Department 1515 Silver Springs Blvd. Suite 206 Ocala, Florida 34470 T: 352-205-4788 F: 352-512-0097

Tips for quickest processing

- Enter client's name, DOB, SSN and Medicaid number to exactly match their Medicaid information

- Fill out the Protected Health Information (PHI) form and send with referral for each agency and family member who will require records or access to client information.

- Include proof of guardianship for clients under 18. Proof of guardianship must state client and guardian's names. Documents may include:
  1. Client's birth certificate
  2. Court order
  3. Power of attorney