

THE CHRYSALIS GROUP INC.

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Authorization Form

Complete this form to authorize me to release protected information from your clinical record to the person you designate.

I authorize my psychotherapist, _____, to release _____
_____ (description of information).

This information should only be released to:

Name: _____

Address: _____

I am requesting this release of information for the following reason:

I understand that information received from another health care provider cannot be redisclosed if that health care provider requests that the information not be redisclosed.

This authorization shall remain in effect until _____ (date not to exceed one year)

You have the right to revoke this authorization at any time by sending written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that I have a right to refuse authorization unless it is for the purpose of providing health information for the purposes of third party reimbursement.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient

Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.