

Chrysalis
844 Williamson St.
Madison, WI 53703
Phone: (608) 256-3102
Fax: (608) 256 -3103

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

NOTE: All matters relating to Client records are considered privileged and confidential and are treated as such by the employees of Chrysalis. Information regarding such matters cannot be given without the consent of the Client

I, _____ authorize _____.
(Name of Client) (Name of Agency)

Address: _____

Phone #: _____

To obtain from: Chrysalis, Inc. To release to: Chrysalis, Inc.

Information from my records that may include: Mental health history, independent living skills, income, vocational skills, psychological and social functioning, health history and diagnosis, drug and alcohol history and education and training.

The purpose or need for such disclosure is: **TO FACILITATE VOCATIONAL PLANNING**

THIS CONSENT EXPIRES: _____
(One year from date signed)

NOTE: This consent to disclose may be revoked by me at any time, except to the extent that action has been taken in reliance thereon.

(Signature of Client or persons authorized to consent)

(Date signed)

Relationship of person other than client signing: _____

