Chrysalis

Vocational Peer Support Referral

Persons with lived experience with mental illness support peers as they navigate their individual road to recovery through employment.

Name:	Date:	
Client ID #:	MA #:	D.O.B.:
Address:	Phone:	
Diagnosis/ICD-10 Code:	SSN:	
Referring Agent:	Referring Agency:	
How could a Vocational Peer Specialist support you and your vocational goals?		

Example of Vocational Peer Support Activities (check all of interest to you):

- ☐ Assist in obtaining services that meet my recovery needs
- ☐ Discuss problem solving techniques' when symptom increase
- ☐ Explore work and education goals
- ☐ Support with finding volunteer work
- ☐ Peer-lead recovery group
- ☐ Other:

_____

Signature of consumer or persons authorized to consent Date

_____

Signature of person making referral Date

Chrysalis

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Consumer Name: _____

I hereby authorize Chrysalis to (check all that apply): ☐ Obtain from the following;
☐ Release to the following;

Name: _____

Address: _____

Information to obtain/release	**Check all that apply**
Treatment Plans	
Work Related	
Mental Health	
Educational	
Current/Past Health Records	
Criminal Background	

This consent expires (one year from date signed): _____

NOTE: The purpose or need for such disclosure is to best assist an individual with success in achieving their vocational goals. 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 consumer or persons authorized to consent Date

_____

Relationship of person signing release Date

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