



## Individual Placement and Support (IPS) Supported Employment Referral

*An evidence-based approach to paid competitive employment*

Name:	Date:	
Client ID #:	MA #:	D.O.B.:
Address:	Phone:	
ICD-10 Diagnosis Code:	SSN:	
Case Manager/Service Facilitator:	Mental Health Treatment Team:	
What are some of your work goals?		
What kind of support would you like to reach your work goals?		
What job (type of job, hours, etc) do you think would be a good match?		

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Signature of consumer or persons authorized to consent

Date

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Signature of person making referral

Date



**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION: MENTAL HEALTH TEAM**

Consumer Name: \_\_\_\_\_

I hereby authorize Chrysalis to release and obtain information from the following:

\_\_\_\_\_  
Mental Health Team & Address

Release Information that pertains to individual vocational goals including but not limited to;

- Job development
- Job coaching
- Mental health information
- Financial information

Obtain Information that pertains to individual vocational goals including but not limited to;

- Mental health background and current status
- Criminal Justice background
- Financial information
- Housing information
- Medication information

The purpose or need for such disclosure is to best assist an individual with successful job placement.

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

\_\_\_\_\_  
Relationship of person signing authorization

\_\_\_\_\_  
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.



Supporting work opportunities that encourage hope, healing, and wellness.

## Chrysalis Telehealth Informed Consent

I hereby consent to participate in telemental health services with Chrysalis as part of my psychosocial rehabilitation services. I understand that telehealth is the practice of delivering health care services via technology assisted media or other electronic means when two people are located in different locations.

I understand the following with respect to telehealth communication:

1. I understand that there are risks associated with telehealth, such as confidentiality breaches if someone should walk into the room or technical difficulties that may result in service interruptions. If we are unable to reconnect with video, we may resume our session with regular voice communication.
2. I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in all of these, my information will be kept private.
3. I understand that although my provider makes every effort to protect my privacy by using a secure server, they cannot guarantee the security of any information transmitted over the internet. By using telehealth services, I recognize that transmissions over the internet are at my own risk and that third parties may unlawfully intercept or access the transmissions.
4. I understand that there will be no recording of any of the online sessions. Information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
5. I understand that I have the right to withdraw consent at any time without affecting my right to future care or treatment.

I have read the information and understand the risks and benefits related to the use of telehealth services. I hereby give my consent to participate in the use of telehealth services.

\_\_\_\_\_  
Printed Name of Client/Legal Guardian

\_\_\_\_\_  
Signature of Client/Legal Guardian

\_\_\_\_\_  
Date

