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:	
ICD-10 Diagnosis Code:	SSN:	
Case Manager/Service Facilitator:	Mental Health Treatment Team:	
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 ☐ 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.

Chrysalis 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