Revised 9/25/14
Chart Section: Financial
Form Responsibility: Financial A/R
Paper Color: purple

Catalyst Life Services
741 Scholl Road
Mansfield, OH 44907
419-756-1717

CONSENT FOR RELEASE OF CONFIDENTIAL ALCOHOL AND/OR OTHER DRUG TREATMENT INFORMATION

I, _____, authorize **Catalyst Life Services** to disclose the following information:

Information required by U.S.C. 290aa-11 Sec 509D, ODADAS, ODMH and the _____County to enroll you in the _____ County Behavioral Health Services plan through the MACSIS claims system, determine your eligibility for public funds and pay your treatment provider for services

to the following person or organization:

_____County, ODADAS and ODMH.

The purpose of this authorized disclosure is to:

Enroll you in the _____County Behavioral Health Services plan through the MACSIS claims system, determine your eligibility for public funds and pay your treatment provider for services.

This consent expires automatically upon the following condition:

365 days after my last treatment after discharge, completion of treatment or last date of treatment.

However, I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

I understand that my records are protected by federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

_____ _____

Date Signature

Out-of-County Form