

Catalyst Life Services
Center for Individual and Family Services
741 Scholl Road, Mansfield, OH 44907
(419) 756-1717 Fax (419) 756-5832
The Rehab Center - (419) 756-1133 Fax (419) 756-6544
New Beginnings Recovery Services - (419) 526-6168 Fax (419) 526-2015

IMPORTANT: This AUTHORIZATION FOR RELEASE OF INFORMATION form is only valid if it is signed, dated, signed by a witness and all sections are filled in. Incomplete Authorization forms are invalid and will be returned to the person who requested the information.

Client's Name: _____ Date of Birth: _____

SS#: _____

This form authorizes **Catalyst Life Services** to:

- _____ DISCLOSE or RELEASE personal health information to
- _____ RECEIVE personal health information from
- _____ EXCHANGE personal health information with

Please check box if copies of notes or forms are to be sent.

 (Individual/Organization)

 (Street Address) (City) (State) (Zip Code)

 (Telephone) (Fax Number)

PURPOSE OR NEED for disclosure MUST be checked or written below for this form to be valid:

- Continuity of care/coordination of treatment
- Inform Criminal Justice Agency of progress in treatment
- Gather assessment information for treatment planning
- Gather information for on-going treatment
- At request of client/individual
- Other (specify in detail) _____

DESCRIPTION OF THE INFORMATION to be released MUST be checked or written below for this form to be valid:

- Alcohol/Drug (AOD)
- AOD Assessment (may include MH assessment or screening)
 - AOD Progress Notes
 - AOD Discharge Summary
 - AOD Treatment Plans
 - AOD Diagnosis
 - AOD Treatment Dates/Attendance
 - AOD Compliance
 - AOD Recommendations
 - Lab Reports/Drug Screen Reports
 - Other (specify in detail) _____

- Mental Health/Medical/Vocational/Other
- Diagnostic Assessments
 - Case Management Assessment/Notes
 - Psychological Testing Summary
 - Initial Psychiatric/Medical Evaluation
 - Psychiatric/Medical Progress Notes
 - Counseling Progress Notes
 - Discharge Report/Discharge Summary
 - Treatment Plans
 - Diagnosis/ Diagnostic Test Results
 - Treatment Dates/Attendance/Compliance
 - Lab Reports/Drug Screen Reports
 - Evaluation Reports
 - Other (specify in detail) _____
