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#:				
RECEIVE pers	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	e)
(Telephone)		(Fax Number)		
PURPOSE OR NEED for disclosure MUST be c Continuity of care/coordination of treatment Inform Criminal Justice Agency of progress in treatment Gather assessment information for treatment planning	hecked or	Written below for this form to be valid: Gather information for on-going treatment At request of client/individual Other (specify in detail)		
DESCRIPTION OF THE INFORMATION to b be valid:	e released	MUST be checked or wri	tten below	for this form to
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/Medica Diagnostic Assessment Case Management Ass Psychological Testing Initial Psychiatric/Med Psychiatric/Medical Pr Counseling Progress N Discharge Report/Disc Treatment Plans Diagnosis/ Diagnostic Treatment Dates/Atten Lab Reports/Drug Scree Evaluation Reports Other (specify in detail	essment/No Summary ical Evaluat ogress Note fotes harge Sumn Test Results dance/Comp	tes tion s nary s pliance

Information will be released from the most recent below: Other (specify in detail)	or current admission to the agency unless otherwise indicated
Authorization expiration date will be 180 days (6). This authorization expires (specify date, event,	months) after the date signed <u>unless otherwise indicated below.</u> and/or condition):
this authorization. I do not need to sign to needed for participation in a research study understand that I may inspect or obtain a I have the right to request a shorter duration. This consent is subject to rewho is to make the disclosure has already	e disclosure of this information is voluntary. I can refuse to sign his form to assure treatment. However, if this authorization is dy, my enrollment in the research study may be denied. I copy of the information to be used or disclosed. I understand that ion for this authorization by indicating the expiration date above. evocation at any time except to the extent the program or person acted in reliance on it. The services may receive compensation for the uses and
federal rules prohibit you from making and is expressly permitted by the written constant 42 C.F.R. part 2. A general authorization	ou from records protected by federal confidentiality rules. The my further disclosure of this information unless further disclosure sent of the person to whom it pertains or as otherwise permitted by a for the release of medical or other information is not sufficient at any use of information to criminally investigate or prosecute any
re-disclose this information to a third party. I	t guarantee that the recipient of this information will not understand that treatment, payment, enrollment or orization. I understand that I can request a copy of this
This form has been fully completed before signi	ing and I agree to any conditions stated above.
Signature of Client or Guardian	Date
Witness	Date
Client's Name (PRINT)	
Printed Name of Guardian (if applicable)	Relationship to the Client (if applicable)
	ng the request in writing and giving it to the Medical Records g about information that Catalyst Life Services has already released
I hereby revoke this release of information:	
Signature:	Date: