

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 OHMAS and the _____ County to enroll you in the _____ County Behavioral Health Services plan through the GOSH claims system, determine your eligibility for public funds and pay your treatment provider for services.

to the following person or organization:

_____ **County, OHMAS.**

The purpose of this authorized disclosure is to:

Enroll you in the _____ County Behavioral Health Services plan through the GOSH claims system, to 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