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 Richland County Mental Health and Recovery Board to enroll you in the Richland 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:

Richland County Mental Health and Recovery Board, and OHMAS.

The purpose of this authorized disclosure is to:

Enroll you in the Richland 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