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

CONSENT FOR RELEASE OF CONFIDENTIAL SUBSTANCE USE DISORDER TREATMENT/ MENTAL HEALTH TREATMENT INFORMATION

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

Treatment episode information such as admission, transfer, discharge, and annual update records. This includes employment status, educational status, living arrangement, criminal justice involvement and social connectedness information. Other information to be disclosed includes smoking status, military status, referral source, pregnancy status, primary source of income, diagnosis, special population information (i.e. nonconforming gender identity, trauma history, deaf/hard-of-hearing), and discharge reason.

To the following organizations:

Ohio Mental Health and Addiction Services (OMHAS) and the Mental Health and Recovery Services Board of Richland County

The purpose of this authorized disclosure:

Providers certified or licensed by OMHAS to provide behavioral health services are required under Ohio Revised Code 5119.61 and Ohio Administrative Code 5122-28-04 to report information in the Ohio Behavioral Health Information System (OBHIS). The department shall collect information about services and persons served as required for reporting and evaluation relating to state and federal funds for such purposes.

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.

I understand that this consent does not expire as client data cannot be retracted once it has been entered into the system. However, I do reserve the right to deny authorization for subsequent disclosure(s), if and when applicable.

Client/Guardian Signature: _____ **Date:** _____

Staff/Witness Signature: _____

10/5/2020