Catalyst Life Services

The Center, 741 Scholl Road, Mansfield, OH 44907 - Phone 419-756-1717 Fax 419-756-5832
The Rehab Center, 270 Sterkel Blvd., Mansfield, OH 44907 - Phone 419-756-1133 Fax 419 756-6544
Shelby Office, 142 N. Gamble Street, Suite G, Shelby, OH 44875 - Phone 419-342-2449 Fax 419-342-2384
New Beginnings Recovery Services I, 711 Scholl Road, Mansfield, OH - Phone 419- 526-6168 Fax 419- 526-2015
New Beginnings Recovery Services II, 703 Scholl Road, Mansfield, OH - Phone 419-774-6770 Fax 419-774-6810
Withdrawal Management Center, 707 Scholl Rd., Mansfield, OH 44907 – Phone 419-774-6778 Fax 419-774-6815

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

Client's Full Name: _____

Date of Birth:_____ SS#: XXX-XX-_____

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)

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

☐ 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)_____

_____
_____

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

<u>Substance Use Disorder Treatment (SUD)</u>

☐ SUD Assessment (may include MH assessment/screening or diagnosis)
☐ SUD Progress Notes
☐ SUD Discharge Summary
☐ SUD Treatment Plan
☐ SUD Diagnosis (may include Mental Health Diagnosis)
☐ SUD Treatment Dates/Attendance
☐ SUD Compliance
☐ SUD Recommendations
☐ Lab Reports/Drug Screen Reports
☐ Vivitrol Donor Program Form
☐ Medications
☐ Other (specify in detail)_____

_____

<u>Mental Health Services/Medical/Vocational/Other</u>

☐ Diagnostic Assessment (may include Initial Psychiatric Evaluation. in lieu of diagnostic assessment)
☐ Case Management Assessment/Notes
☐ Psychological Testing Summary
☐ Initial Psychiatric/Medical Evaluation/Assessment
☐ Psychiatric/Medical Progress Notes
☐ Counseling Progress Notes
☐ Discharge Report/Discharge Summary
☐ Treatment Plan
☐ Diagnosis/ Diagnostic Test Results
☐ Treatment Dates/Attendance/Compliance
☐ Lab Reports/Drug Screen Reports
☐ Evaluation Reports/Forms
☐ Other (specify in detail) _____

_____

I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse.

Information will be released from the most recent or current admission to the agency unless otherwise indicated below:
☐ Other (specify in detail) _____

Authorization expiration date will be ☐ 180 days (6 months) ☐ 1 Year after the date signed unless otherwise indicated:
☐ This authorization expires (specify date, event, and/or condition):

- **Rights:** I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that I have the right to request a shorter duration for this authorization by indicating the expiration date above.
- **Revocation:** This consent is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it.
- **Compensation:** I understand that Catalyst Life Services may receive compensation for the uses and disclosures that I have authorized.

- This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

I understand that Catalyst Life Services cannot guarantee that the recipient of this information will not re-disclose this information to a third party. I understand that treatment, payment, enrollment or eligibility of benefits are not based on this authorization. I understand that I can request a copy of this form.

This form has been fully completed before signing and I agree to any conditions stated above.

_____ _____
Signature of Client or Guardian Date

_____ _____
Witness (Optional) Date

_____
Client's Full Name (PRINT)

_____ _____
Printed Name of Guardian (if applicable) Relationship to the Client (if applicable)

I may revoke this authorization at any time by putting the request in writing and giving it to the Medical Records Department. I understand that I cannot do anything about information that Catalyst Life Services has already released while the authorization was in force.

I hereby REVOKE this release of information:

Signature:_____ Date:_____
Revised 3/2023