**DATE:**

**Student Full Name:**

First MI Last Maiden/Alias

**DOB: \_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_ Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_---\_\_\_\_\_\_\_\_\_\_\_\_\_--- \_\_\_\_\_\_\_\_\_\_\_\_\_**

**School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| I authorize release of the following records for the above  named student ***TO*** representatives of Catalyst Management,  Incorporated (aka “Catalyst Behavioral Health”):  🞎 Official administrative record (name, address, DOB, grade level completed, grades, class standing, attendance record)  🞎 Standardized achievement test scores  🞎 Intelligence and aptitude test scores  🞎 Personality and interest test scores  🞎 Teacher and counselor observations and ratings  🞎 Record of extracurricular activities  🞎 Family background data  🞎 Health/Immunization records  🞎 Special Education records  🞎 Other:  🞎 No restrictions | I authorize release of the following records/information for  the above-named student ***FROM*** representatives of Catalyst  Management, Incorporated (aka “Catalyst Behavioral Health”)  to theidentified school:  🞎 Official administrative record (name, address, DOB)  🞎 General treatment goals  🞎 General progress toward identified goals  🞎 Other:  🞎 No restrictions |

|  |  |
| --- | --- |
| DISCLOSURE | |
| *One-time Use/Disclosure* | I authorize the one-time use or disclosure of the information described above to the person/ provider/ organization/ facility/ program(s) identified.  My authorization will expire:  When the requested information has been sent/received.  90 days from this date.  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| *Periodic Use/Disclosure* | Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/ provider/ organization/ facility/ program(s) identified as often as necessary to fulfill the purpose identified in this document.  My authorization will expire:  When I am no longer receiving services from Catalyst.  One year from this date.  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Parent/Guardian/Eligible Emancipated Student Signature Date**

**Catalyst Representative Signature Date**