**DATE:**

**Student Full Name:**

 First MI Last Maiden/Alias

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

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

|  |  |
| --- | --- |
| I authorize release of the following records for the abovenamed 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 forthe above-named student ***FROM*** representatives of CatalystManagement, 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**