Name: Date of Birth: SS#:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *I authorize Catalyst to release information to the facility/person listed below:* | | | | *I authorize Catalyst to obtain information from the facility/person listed below:* | | |
| Name of Provider/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City, ST, ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone/Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Name of Provider/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City, ST, ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone/Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| *Purpose of this Request* | | Healthcare Insurance Coverage Personal Continuity of Care  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| *Specific Information Authorized* | | Assessments Progress Notes Diagnostic Impression Discharge Summary  Treatment Plans Treatment Summary  Laboratory Test Results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| *Method* | | Requested documents/information may be released in the following manner(s):  Mail Verbal Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Electronic (E-mail, etc.) | | | | |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| *Authorization is hereby granted to Catalyst and its staff to obtain and/or release information from/to all or any part of the agencies that are specifically and legitimately involved in the individual’s diagnosis, treatment, and service delivery with information to be retained in the individual’s record. Agencies/contacts include but are not limited to: Case Coordinator, Department of Community Based Services, Division of Behavioral Health, the Division of Mental Health and Substance Abuse, Peer Review Organization, Office of Inspector General, Licensing and Regulation, Veterans’ Administration, Social Security, Social Insurance, and any licensing/regulation board or committee, medical professional and/or mental health specialist. Permission is granted for all chosen providers to share information with each other as necessary. Permission is also given for Catalyst to share information (obtain or release) with other support services outside the program, such as medical, dental, vision, counseling, psychiatric, hospitals, prisons, etc. in order to provide the best possible health, continuity of care, and to conduct routine business. I also understand that information may be shared with additional relevant third-parties, such as insurance providers or other payer sources. I also understand that some insurance providers require disclosure of a diagnosis in order to render payment for services and hereby authorize such diagnosing and the release thereof. I understand that my information may be discussed with other professionals to ensure that treatment and services provided to me are suitable and in my best interest and hereby authorize this disclosure. Also, as we are a regulated program by the Division of Mental Health and Substance Abuse and their affiliated agencies, participants’ information may be requested to conduct surveys of our program, as well as information may be shared to the Department for Community Services as required to maintain services and provider payment status. I authorize the Case Coordinator, Program Administrator, or delegated staff to send and receive information as needed to maintain the participant’s care. I authorize the Case Coordinator, Program Administrator, or delegated staff to act as agent on my behalf during appointments with the Department of Social Insurance and when working with the Social Security Administration. I authorize these agencies to furnish information to Catalyst including benefit eligibility/verification, medical/social/psychiatric/legal history, etc. I understand and authorize this release form to serve as an authorization for the type of releases described in this section. Any information listed in this document may be released by the following methods: verbally, mail, fax, and/or e-mail. Any information in this document may be released by the following methods: verbally, mail, fax, and/or e-mail. I acknowledge that this consent was presented to me and I understand that I may limit this authorization by doing so in writing to the Case Coordinator or Program Administrator.* | | | | | | |
| **CLIENT SIGNATURE** | | |  | | **DATE** |  |
| **CATALYST REPRESENTATIVE/TITLE** | | |  | | **DATE** |  |