

Alcohol and Drug Addiction Services Board of Lorain County
Outline for Success Stories
Clients, Family Members, Partners

Client Success Story

The story should include:

- Person's name, age, and hometown
- Living situation (e.g. with family/children/independent, etc)
- What led them to start using alcohol or other drugs?
- How did drug abuse/addiction impact their life?
- What led to them to get help?
- How is their life better today because of ADAS' investment in clinical treatment and/or recovery support services?

Family Member/Ally Success Story

The story should include:

- Family Member's/Ally's name, age, hometown
- What is your relationship to the loved-one you are talking about?
- Description of the types of services and supports you have accessed
- How has this helped you personally?
- How has this assisted your role as a loved one of a person struggling with Addiction?

Partner Success Story

The story should include:

- Partner's name, age, hometown
- What is your affiliation with ADAS Board and/or substance abuse treatment, prevention providers?
- Description of the types of services and supports you have partnered with regarding substance use, addiction?
- How has this helped the population(s) you are affiliated/work with?

Alcohol and Drug Addiction Services Board of Lorain County SUCCESS STORY

AUTHORIZATION TO RELEASE INFORMATION

Authorization for publishing information about :				
NAME	LAST	FIRST	MIDDLE	DOB:
Mailing Address: _____ Email Address: _____				
Release information to:				
ORGANIZATION OR AFFILIATION				
Alcohol and Drug Addiction Services Board of Lorain County				
TELEPHONE NUMBER (INCLUDE AREA CODE)		FAX NUMBER (INCLUDE AREA CODE)		E-MAIL ADDRESS
(440) 282-9920		(440) 282-9928		georgas@lorainadas.org
ADDRESS		CITY	STATE	ZIP CODE
4950 Oberlin Avenue		Lorain	OH	44053
REASON FOR RELEASE				
To provide information and/or photographs for publications developed by the Alcohol and Drug Addiction Services Board of Lorain County, to promote education about the investment in substance abuse treatment and recovery support services effectiveness in servicing individuals recovering from addiction.				
Authorization for release:				
I authorize the Alcohol and Drug Addiction Services Board of Lorain County, and the following programs if applicable, to release information about my participation in substance abuse treatment programs and/or family support programs or partnerships, for publishing by the Alcohol and Drug Addiction Services Board of Lorain County. I understand that information may be provided verbally or by computer data transfer, mail, fax, or hand delivery:				
Name and Address of Treatment Agency, or Family Support Program and contact person:				
1) _____				
2) _____				
I understand and agree to the release of information authorized in this form. I understand I may revoke this release in writing at any time, but I understand that revocation will not affect any information that was already released. A copy of this form is valid to give my permission to release records.				
AUTHORIZED BY (SIGNATURE)		DATE SIGNED		TELEPHONE NUMBER (INCLUDE AREA CODE)
PRINT NAME				
If I am not the person whose information is being released, I am authorized to sign because I am the:				
<input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian (attach court order) <input type="checkbox"/> Other:				

To those receiving information under this authorization: Federal and state laws and regulations protect the information disclosed to you. You may not release it to any other person or entity without specific written consent. You are subject to the same standards and laws of confidentiality as the originating holder of the records.

Signed authorizations are required for all stories submitted. Please email a scanned PDF version of the authorization to release information along with the written success story to Elaine Georgas (georgas@lorainadas.org).