Aloha House /Maui Youth and Family Services /Malama Family Recovery Center

AUTHORIZING DISCLOSURE OF CONFIDENTIAL PATIENT RECORDS

I _____and/or _____(relationship to client) authorize employees of

☐Aloha House ☐Maui Youth and Family Services, ☐Malama Family Recovery Center
P.O. Box 791749, Paia, Maui, Hawaii 96779 to

___Disclose information to AND/OR ___ obtain information from

_____
Print name of agency, attorney, health care professional, etc.

_____
Address, city, state, zip code

Phone ( ) _____ Fax ( ) _____

Regarding _____ (Name of Client) _____ (DOB)

MEDICAL RECORDS:

The records covered by this authorization are LIMITED to the following types of records or information and I understand that I may change my mind at any time by a written instruction to AHI/MFRC/MYFS:

Client to initial each item to be released:

____ Admission History/presence in Treatment
____ Psycho-social History and Assessment
____ Educational Assessment and grades
____ School Attendance
____ Treatment Plan
____ Psychiatric Med Eval/monitoring
____ Substance Abuse Assessment
____ Discharge Summary
____ Substance Use Test Results
____Monthly Treatment Reports
____Mental Health/Psychiatric Evaluation
____Verbal and written information pertaining to Client's behavior and needs for the purpose of providing and verifying treatment.
____ Health status and history
____ Consult (s)
____ Other_____
____ Program Attendance

____I DO NOT agree to the release of HIV/AIDS status or alcohol/drug abuse information (circle those that apply). I understand that my record will be marked as "redacted" and information regarding my status will be removed.

The purpose of the disclosure authorized hereby is to provide:

____ Coordination of Services ____Contact with my referral source ____Facilitate Access to Services
____ Treatment Planning ____Litigation
____ Other _____

Fees:

☐ $6.50 Electronic copies ☐ $18 Paper copies ☐ Special request (cost to be determined)

Please make check payable to ALOHA HOUSE.

I was verbally informed of the risks, (unintended re-release, sharing information with persons not authorized) benefits (continuity and coordination of care) and alternatives (refusing release) to signing a release/request for information and have received a copy. that I do not have to agree to release confidential information except as required by law or under the requirements of my insurance policy (as detailed in the Notice of Privacy Practices), and that I may withdraw this consent at any time except insofar as action has already been taken. I also understand that I may refuse to sign and doing so will not affect my ability to access services. A fax of this form is as valid as the original. If not previously revoked, this consent will terminate one year from signing or the following date _____

_____ _____ _____ _____
Signature of client TODAY'S Date Signature of Legal Guardian TODAY'S Date

_____ _____
Signature of Agency Representative Date

If information has been disclosed to you relating to substance abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2 and 45 CFR Parts 160 &164)) 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 CFR 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient. INFORMATION RELEASED MAY NOT BE RE-RELEASED WITHOUT WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS.

For Office Use: If client is not personally known to the agency, client's identity was verified by:

- □ Driver's License (specify type and number)_____ Other Photo ID_____
- □ Office Staff Signature and title_____