Kokua Support Services

*A Path for a Better Tomorrow*

# CONSENT FOR CONFIDENTIAL INFORMATION

Check appropriate: [X] Consent to Release Confidential Information. [X] Consent to Obtain Confidential Information.

This information may be transmitted: [X] [X] In Writing [X] By Fax [X] By Internet [X] In Person

I, ______________________________________________

(Name of client, parent, guardian or legal representative)

Hereby authorize the disclosure & receipt of information between : **AUTHORIZED PERSONNEL OF KOKUA SUPPORT SERVICES.**

(Name of authorized/designated staff member of K.S.S.)

and ______________________________ Ph: # ______________

(Name of person/organization between which information is shared)

**The disclosure of information authorized herein is required for the following purpose's):** Collateral Information, Case Management, Care Coordination, Substance Abuse & Vocational Screening and Assessment Results and Recommendations, Referral for Treatment Services, Representative Payee Services & Coordination, 6 month follow up evaluations

**and such disclosure shall be limited to the following specific types of information:** Collateral information regarding client's Diagnosis, treatment planning, progress, participation, coordination of services for client care. vocational and substance abuse rehabilitation, budget and benefit handling, and employment related concerns.

I understand that:

- My alcohol and/ or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 CFR Part and Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Pts, 160 & 164.
- Generally, KSS may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances, I may be denied treatment if I do not sign a consent form.
- Information cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- I may revoke this consent in writing at any time except that action has been taken in reliance on it. This consent expires automatically within one year or sooner as follows:

__________ **: or until discharge plus 30 days**

This information disclosed shall be confidential and further disclosure to any other person/organization is prohibited without my specific written consent.

**By initialing below I authorize the following Protected Health Information to be used/disclosed as relevant:**

__________ : Substance Abuse Records

__________ : General Medical Records

__________ : Psychiatric Records

__________ : HIV / AIDS Records

**Dated:** ______________________

**Client Signature:** ______________________

**KSS Clinician/Witness:** ______________________

**PH: 808-847-4227**

**FAX: 808-842-0044**

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