PO'AILANI, INC.
Continuum of Care

Consent to Obtain and/or Release Confidential Alcohol, Drug, Mental Health Recovery Information

I ______________________________, authorize
Resident/Consumer Printed Name

(1) Po'ailani, Inc. Continuum of Care

And

(2) ____
Name of Funding Source/Insurance

I understand that the purpose of this consent is to obtain and/or release personal information about me with regard to recovery and/or housing at Po'ailani, Inc.

[Initial Each Category that Applies]

____ My name and other personal identifying information
_____ My status as a consumer in alcohol, drug and/or mental health recovery
_____ Date of admission and attendance dates
_____ Assessment, evaluation results and history
_____ Summary of recovery plan, progress and compliance
_____ Date of discharge, discharge plan

I understand that my alcohol, drug and/or mental health recovery records are protected under the federal regulations governing the Confidentiality of Alcohol, Drug Abuse Patient Records and/or Mental Health Patient Records, 42 .C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in regulations.
(From Confidentiality and Communication: A Guide to the Federal Drug & Alcohol Confidentiality Law and HIPAA. New York: Legal Action Center of the City of New York, Inc., 2006, p. 242)
"PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION" "This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). 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 pertain or as otherwise permitted by 42 C.F.R. 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."
I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows.

Please circle and initial either number 1 or number 2, whichever applies

_____ 1. Until all payments for services have been fully paid for by the funding source

OR

2. Specify earlier date if required by State law :__________________________________

I understand that this information may be communicated verbally, in writing, by fax, or electronically

Resident/Consumer Signature:______________________________ Date: ______________

Staff Signature: ____ Date: ______________
8.07.18

PO'AILANI, INC.
Continuum of Care

Authorization To Release Confidential Medical, Alcohol, Drug, Mental Health Recovery Information

I ____, DOB: ________________
(Resident/Client Printed Name)

Authorize: ____

(Facility in Possession of Record)

The release of the following protected health information to Po'ailani Inc.:

I understand that the purpose of this consent is to obtain and/or release personal information about me with regard to treatment and/or housing at Po'ailani, Inc.

[Initial Each Category]

_______**Mental Health/Behavioral Health/Psychiatric Care/Psychiatric Treatment Records**

_______**Alcohol/Substance Abuse Treatment Records**

_______**Physical Examination Records/TB Clearance/Diet Order/Medication Report**

_______**HIV Screening and Diagnostic Results/Treatment Records**

I understand that my alcohol, drug and/or mental health recovery records are protected under the federal regulations governing the Confidentiality of Alcohol, Drug Abuse Patient Records and/or Mental Health Patient Records, 42 .C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in regulations.
(From Confidentiality and Communication: A Guide to the Federal Drug & Alcohol Confidentiality Law and HIPAA. New York: Legal Action Center of the City of New York, Inc., 2006, p. 242) **"PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION"** "This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). 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 pertain or as otherwise permitted by 42 C.F.R. 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."
I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows.

Resident/Client Signature:_________________________________ Date: __________________

Staff Signature: ____ Date: __________________

8.7.18

PO'AILANI, INC.
Continuum of Care

Consent to Obtain and/or Release Confidential Alcohol, Drug, Mental Health Recovery Information

I ______________________________, authorize
Resident/Consumer Printed Name

(1) Po'ailani, Inc. Continuum of Care

And

(2) ____
(Emergency contact, friend, family, support person, or other)

Phone# __________________________

I understand that the purpose of this consent is to obtain and/or release personal information about me with regard to recovery and/or housing at Po'ailani, Inc.

[<u>Initial</u> **Each Category that Applies]**

_____ My name and other personal identifying information
_____ My status as a consumer in alcohol, drug and/or mental health recovery
_____ Date of admission and attendance dates
_____ Assessment, evaluation results and history
_____ Summary of recovery plan, progress and compliance
_____ Date of discharge, discharge plan

I understand that my alcohol, drug and/or mental health recovery records are protected under the federal regulations governing the Confidentiality of Alcohol, Drug Abuse Patient Records and/or Mental Health Patient Records, 42 .C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in regulations.
(From <u>Confidentiality and Communication: A Guide to the Federal Drug & Alcohol Confidentiality Law and HIPAA.</u> New York: Legal Action Center of the City of New York, Inc., 2006, p. 242) **"PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION"** "This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). 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 pertain or as otherwise permitted by 42 C.F.R. 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."
I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows.

Please circle and initial either number 1 or number 2, whichever applies

_______ 1. Six months after leaving Po'ailani Inc. Continuum of Care

OR

2. Specify earlier date if required by State law :______________________________

I understand that this information may be communicated verbally, in writing, by fax, or electronically

Resident/Consumer Signature: ______________________________ Date: ______________

Staff Signature: ____________________________________ Date: ______________

PO'AILANI, INC.
Continuum of Care

Consent to Obtain and/or Release Confidential Alcohol, Drug, Mental Health Recovery Information

I ______________________________, authorize
Resident/Consumer Printed Name

(1) Po'ailani, Inc. Continuum of Care

And

(2) ______________________________ (CASE MANAGER)
Name of Person and Organization

I understand that the purpose of this consent is to obtain and/or release personal information about me with regard to recovery and/or housing at Po'ailani, Inc.

[Initial Each Category that Applies]

_____ My name and other personal identifying information
_____ My status as a consumer in alcohol, drug and/or mental health recovery
_____ Date of admission and attendance dates
_____ Assessment, evaluation results and history
_____ Summary of recovery plan, progress, and compliance
_____ Date of discharge, discharge plan

I understand that my alcohol, drug and/or mental health recovery records are protected under the federal regulations governing the Confidentiality of Alcohol, Drug Abuse Patient Records and/or Mental Health Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in regulations.
(From Confidentiality and Communication: A Guide to the Federal Drug & Alcohol Confidentiality Law and HIPAA. New York: Legal Action Center of the City of New York, Inc., 2006, p. 242) **"PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION"** "This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). 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 pertain or as otherwise permitted by 42 C.F.R. 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."
I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows.

Please circle and initial either number 1 or number 2, whichever applies

1. Six months after leaving Po'ailani Inc. Continuum of Care

OR

2. Specify earlier date if required by State law : ______________________________

I understand that this information may be communicated verbally, in writing, by fax, or electronically

Resident/Consumer Signature: ______________________________ Date: ______________

Staff Signature: ______________________________ Date: ______________

112206

PO'AILANI, INC.
CONTINUUM OF CARE
CRIMINAL JUSTICE SYSTEM CONSENT FORM

Consent for Release of Confidential Information: Criminal Justice System Referral

I ________________________, hereby consent to communication between

Po'ailani, Inc. and ____ & agents
(Probation/Parole Officer's full name and contact info)

Phone# __________________ **Fax#** ____________________

The purpose of and need for the disclosure is to inform the criminal justice agency listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, urinalysis testing.

I understand and consent to with my <u>initials</u> that this consent will remain in effect and cannot be revoked by me until:

_____ There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment,

_____ Three months after leaving Po'ailani Inc. Continuum of Care

I understand that my alcohol, drug and/or mental health recovery records are protected under the federal regulations governing the Confidentiality of Alcohol, Drug Abuse Patient Records and/or Mental Health Patient Records, 42 .C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in regulations.
(From <u>Confidentiality and Communication: A Guide to the Federal Drug & Alcohol Confidentiality Law and HIPAA.</u> New York: Legal Action Center of the City of New York, Inc., 2006, p. 242)
"PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION" "This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). 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 pertain or as otherwise permitted by 42 C.F.R. 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."
I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows.

I understand that generally Po'ailani, Inc. may not condition my treatment on whether I sign a consent form, but in certain limited circumstances I may be denied treatment if I do not sign a consent form.

I understand that this information may be communicated verbally, in writing, by fax, or electronically

Resident/Consumer Signature:________________________________ Date: ______________

Staff Signature: ______________________________________ Date: ______________

Revised 042305 112206 031008

PO'AILANI, INC.
CONTINUUM OF CARE
CRIMINAL JUSTICE SYSTEM CONSENT FORM

Consent for Release of Confidential Information: Criminal Justice System Referral

I ________________________, hereby consent to communication between

Po'ailani, Inc. and ____ & agents
(Attorney or Public Defender's full name and contact info)

Phone# __________________ **Fax#** ____________________

The purpose of and need for the disclosure is to inform the criminal justice agency listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, urinalysis testing.

I understand and consent to with my **initials** that this consent will remain in effect and cannot be revoked by me until:

_____ There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment,

_____ Three months after leaving Po'ailani Inc. Continuum of Care

I understand that my alcohol, drug and/or mental health recovery records are protected under the federal regulations governing the Confidentiality of Alcohol, Drug Abuse Patient Records and/or Mental Health Patient Records, 42 .C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in regulations.
(From Confidentiality and Communication: A Guide to the Federal Drug & Alcohol Confidentiality Law and HIPAA. New York: Legal Action Center of the City of New York, Inc., 2006, p. 242)
"PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION" "This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). 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 pertain or as otherwise permitted by 42 C.F.R. 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."
I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows.

I understand that generally Po'ailani, Inc. may not condition my treatment on whether I sign a consent form, but in certain limited circumstances I may be denied treatment if I do not sign a consent form.

I understand that this information may be communicated verbally, in writing, by fax, or electronically

Resident/Consumer Signature:_______________________________ Date: ________________

Staff Signature: _____________________________________ Date: ________________

Revised 042305 112206 031008