State of Hawaii Department of Health

Authorization for Use or Disclosure of Protected Health Information (PHI)

Name of Individual/Organization Disclosing Protected Health Information	
Name: State of Hawaii Department of Health Adult Mental Health Division	Address: P.O. Box 3378 Honolulu, Hawaii 96801-3378
Name of Individual/Organization That Will Receive the Individual's Protected Health Information	
Name: Po'ailani, Inc.	Address: 45-567 Pahia Rd., Kaneohe, HI 96744
Client/Patient Whose Protected Health Information is Being Requested:	
First Name:	Last Name:
Address:	Birth Date (if known):

I Authorize that the Following Protected Health Information be Used/Disclosed: (Be specific. Identify limits, as appropriate. Initial in the space provided if your authorization includes the use/disclosure of specially protected health information)

X_____Mental Health X_____Substance Abuse Treatment X_____HIV/AIDS

The Protected Health Information is Being Used or Disclosed for the Following Purposes (*At the request of the Individual* is an acceptable purpose if the request is made by the individual and the individual does not want to state a specific purpose.):

Authorization Duration (This authorization will be in force and effect until the date *or* event specified below. At that time, this authorization to use or disclose this protected health information expires)

Authorization Expiration Date:	Expiration Event That Relates to the Individual or the Purpose of the Use or Disclosure

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Department of Health. I understand that a revocation is not effective to the extent that the Department has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. However, I understand that information related to education (FERPA, 34 CFR Part 99), alcohol or drug treatment services (42 CFR Part 2) may not be disclosed or redisclosed without my authorization.

The Entity or Person(s) receiving this information will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health Information for disclosure to a third party.

☐ The use or disclosure requested under this authorization will result in direct or indirect remuneration to the Department from a Third Party.

Individual or Personal Representative Signature:	Date:
Print Name of Individual or Personal Representative	Description of Personal Representative's Authority: Self

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) Medquest & agents

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: _____

STATE OF HAWAII
Department of Human Services

Benefit, Employment and Support Services Division

CONSENT TO RELEASE INFORMATION

I _____ , hereby give my
(1) (Circle One: Applicant / Recipient / Legal Guardian)

permission to the Department of Human Services, Benefit, Employment and Support Services Division (BESSD) to release information from their records pertaining to me or my family to:

Po`ailani, Inc. Dual Diagnosis Treatment Center and Agents
(2) (Name of Person / Organization)

(3) The information to be reviewed / released is limited to the following:
DHS case status and all information regarding applicant's standing and eligibility

(4) This information is to be used for: SRSP Residential Treatment Admission Process
(State Purpose)

(5) This consent is good until 1 year from date signed (not to exceed one year from date signed
(month) (day) (year) unless I cancel it in writing to DHS-BESSD)

I understand why the information is being requested, how it will be used, and that this consent is time limited for my protection.

_____ /
(6) *(Signature of Applicant /Recipient / Legal Guardian)* *(7) (Date)*

_____ /
(8) *(Address of Applicant / Recipient)* *(9) (Social Security No.or Birthdate of Applicant/Recipient)*

I hereby agree that the information released will be used only for the purposes stated above and will not be released to any other individual, agency, or organization (HRS 346-10).

_____ /
(10) (Signature of person receiving / reviewing information) *(Date)*

Return Completed Form To:

(11) (Stamp Unit name and address)

_____
(12) Worker's Name *Telephone No.*

Complete two (2) copies:
Original – Case Record Copy – Client

DHS 1465 (Rev. 10/05)