Instructions to Completing Forms
(Please read carefully before completing form below)

1. Make sure you fill out the Screening Information Forms (6 pages) and the attached consents completely. Any missing information may delay the screening and admission process.

2. The consents are very important to complete. Without the consents, Federal law prohibits Hina Mauka from releasing information and we cannot contact the appropriate agencies or individuals to assist in your case. Consents are as follows:
   - **Health Insurance Consents**: Use if you have a medical plan. To be used to authorize services on your behalf. Please list the plan you have (HMSA, Aloha Care, Ohana, etc.).
   - **Legal Non-Provider Entity**: Use if you have a PO, PD, case manager, non-treating/diagnosing agency, etc. List phone number if possible.
   - **Family and Relatives**: Use if you have family, significant other, friends, advocate, etc.
   - **Treating Provider Entity**: Use this form for your doctors and other treating providers (agency or individuals). List phone numbers if possible.

3. If more than one consent is needed, download or make as many copies as you need. One consent per agency, individual or family member.

4. Please download, read and sign the “ADAD and HIPAA Privacy Notice” from the Hina Mauka website.

5. You may also download the “What to Bring” form if you are applying for residential treatment.

6. If you have any medical or psychiatric conditions that require attention, please have all your doctor’s evaluation, medication information and updated reports fax with your application. This will help expedite the screening process. Download “Medical Consents”, complete and sign if we need to contact your doctor. Please fax with your packet.

7. If you are appropriate for services you will be placed on the waitlist (residential only) and a case manager will contact you or your advocate to inform you of such status. **There is no waitlist for Outpatient services.**

8. Once you are approved for admission, a case manager will call you to schedule an admit date. **You are to come in by 9am of the scheduled admit date.** Please plan accordingly.

9. Remember, all forms should be complete. If the information does not apply, please write N/A. Do not leave any blanks.
   **You may also walk in between the hours of 9am to 2pm Monday thru Friday except holidays to apply for services.**

Kaneohe Walk-In Clinic (Residential)
45-845 Pookela Street
Kaneohe, Hawaii 96744
Fax: (808) 236-2626

Waipahu Walk-In Clinic
94-830 Hikimoe Street
Waipahu, Hawaii 96797
Fax: (808) 671-7727

You may also fax all your documents to the appropriate phone numbers on the Screening Information Form. Mahalo!
SCREENING INFORMATION FORM
(To determine eligibility and appropriateness for Hina Mauka services)
(If you do not answer all 36 questions, mark NA)

**Personal Information:**
- Date: ____________________________
- Name: ____________________________
  (First, Middle Initial, Last)
- Home Address: ______________________
- State: ______ City ______
- Zip Code: ______________________
- Home Phone: ______________________
- Cell Phone: ______________________
- Employer: ______________________
- Employment Status (check one):
  - Full-Time ☐ Part-Time ☐ Unemployed ☐
- Health Insurance: __________________
- Membership #: __________________
- Previous Alcohol/Drug Treatment
  - Where ____________________________
  - Date ____________________________
  - Drugs Treated for __________________
    - Completed? ☐ Yes ☐ No
    - Where ____________________________
    - Date ____________________________
  - Drugs Treated for __________________
    - Completed? ☐ Yes ☐ No
  - Have you been in a controlled environment
  - In the past 30 days? (Check one):
    - No ☐ Alcohol/Drug Treatment ☐
    - Yes ☐ Medical Treatment ☐
    - Other ☐ Psychiatric Treatment ☐
- Are you incarcerated now? ☐ Y ☐ N
  - If yes, list the dates below:
  - From: ____________ To: ____________

**Substance Abuse Information:** Please list the type of drugs/alcohol used recently, last date used
(month, day, year, etc.), how much (gram, ½ gram, 1 bottle, etc.), how often (daily, weekly, 3X/month, etc.):

<table>
<thead>
<tr>
<th>Drug Used</th>
<th>Date of Last Use</th>
<th>How Much</th>
<th>How Often</th>
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</tbody>
</table>

**Who referred you?** ☐ CARES ☐ PO ☐ Self ☐ Other
- Referral phone number: __________________
- May we contact them? ☐ Yes ☐ No
- SSN#: __________________
- Birth Date: ____________ Age: ______
- Birth Place: __________________
- Gender (Check all that apply)
  - Male ☐ Female ☐
  - Transgender ☐ Male to Female ☐ Female to Male ☐
- Ethnicity: __________________
- Marital Status (check one):
  - Never Married ☐ Divorced ☐ Widowed ☐ Now Married ☐
  - Separated ☐ Living Together ☐
- Number of Children ___ Ages _____
- Do you have a family member currently in treatment? __________________
- Veteran (circle one):
  - Yes ☐ No ☐
- VA Case Worker: __________________
- Do you smoke cigarettes? ☐ Yes ☐ No
- How much per day? __________________
- Are you pregnant? ☐ Yes ☐ No ☐ N/A
- If yes, how many months? __________________
- Do you use needles to get high? ☐ Yes ☐ No
- If yes, what drug? __________________
- Next of Kin (in case of emergency):
  - Name: __________________
  - Phone: __________________
- Primary Source of Support (check one):
  - Wages/Salary ☐ Disability ☐
  - Public Assistance ☐ Other ☐
  - Retirement ☐ None ☐

Client Name: __________________
- Date: __________________
1. Experience any complications from using or drinking? □ Yes □ No (ex. shakes, moody, cold sweats, medical, psychiatric problems, legal problems, etc.) If yes, explain: ____________________________________________

2. Spend a lot of time using or drinking or recovering from using or drinking? □ Yes □ No  Explain: ____________________________________________

3. Have you given up important activities because of your using or drinking? (Family, work, school, etc.) □ Yes □ No Please explain your answer: ____________________________________________

4. Did you know that using and/or drinking is causing problems for you? □ Yes □ No  If yes, describe these problems: ____________________________________________

5. Do you have a history of overdose? □ Yes □ No. If yes, Last time you overdose? ____________

6. History with detox? □ Yes □ No. If yes, when, where and from what? ____________________________

**Medical/Psychiatric Information:**

7. Do you have a history of seizures? □ Yes □ No. If yes, explain: ____________________________________________

8. Have you ever been told you have any communicable diseases? □ Yes □ No. If yes, What? ______

9. Please provide dates for: Last physical: ________ Last TB test: ________ MMR: ________
   Where: ____________________________________________________________________________________

10. Current medical problems: *(please list condition, how long you had it, treating doctor and medications if any.)*

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>How Long</th>
<th>Treating Physician</th>
<th>Medication(s)</th>
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11. Current psychiatric problems: *(please list condition, how long you had it, treating doctor and medications if any.)*

<table>
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<th>Psychiatric Condition</th>
<th>How Long</th>
<th>Treating Physician</th>
<th>Medication(s)</th>
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</table>

12. Do you know who your Primary Care Physician (PCP) is? □ Yes □ No. If yes please provide:
   Name: __________________ Phone: __________________ Consent to contact? □ Yes □ No

13. Allergies? □ Yes □ No. Describe: ____________________________________________________________

14. Vision problems: □ Yes □ No. Do you wear glasses? □ Yes □ No
15. Hearing problems: □ Yes □ No. Do you wear a hearing aid? □ Yes □ No
16. Do you speak English? □ Yes □ No. If no, do you have an interpreter? □ Yes □ No.
17. Do you have a Case Manager? □ Yes □ No. If yes, please select one of the following:
   □ AMHD □ CER □ ICM □ MHK □ IHS □ CCS □ Other: ________________________
18. Case Manager's Name ______________________ Phone ______________________
19. Do you hear/see/feel things that aren’t there? □ Yes □ No. Describe: ______________________
20. Have you ever attended Anger Management or Domestic Violence classes? □ Yes □ No. If yes, did you complete? □ Yes □ No. Explain: ___________________________________________________________________________
21. Have you ever attempted suicide? □ Yes □ No. Have you thought about it? □ Yes □ No.
    If yes to the above, when? ______________________ Last time? ______________________
    Are you contemplating suicide at this time? □ Yes □ No. If yes, would you consent to us helping you at this time? □ Yes □ No. Describe action taken: ____________________________
22. Have you ever harmed yourself? □ Yes □ No. If yes, would you like someone to talk to about this situation? □ Yes □ No. Describe action taken: ____________________________
23. Have you ever harmed anyone else? □ Yes □ No. If yes, would you like someone to talk to about this situation? □ Yes □ No. Describe action taken: ____________________________

**Legal Encumbrance** *(Applicants must complete this section and sign corresponding consents if applicable)*

1. On probation or parole? □ Probation □ Parole □ HOPE Probation □ Other: _____________
2. Probation/Parole Officer Name: ____________________________ AO#: ______________________
3. Any pending charges? □ Yes □ No. If yes, please describe: ____________________________
4. Were your charges/convictions violent in nature? □ Yes □ No. If yes, please explain ________
5. Pending court dates: ____________________________ When/where? ______________________
6. How many convictions in the past 2 years: ________ Describe: ____________________________
7. Have you ever been a part of a gang? □ Yes □ No. If yes, would it be difficult for you to refrain from gang related activities during treatment? □ Yes □ No
8. CPS/CWS involvement? □ Yes □ No. If yes, may we contact your worker? □ Yes □ No
   Worker name: __________________________ Phone number: __________________________
9. Have you ever been convicted of an offense that was sexual in nature? □ Yes □ No. If yes,
   did you receive treatment for it? □ Yes □ No. Did you complete treatment? □ Yes □ No. If yes,
   please give date of completion: __________ If not, please explain why you did not complete
   treatment: __________________________
10. Have you ever been convicted of a violent crime? □ Yes □ No. If yes, please explain: ________
   __________________________________________
11. How much of your time in the past 2 years, have you engaged in illegal activities?
   □ 25% □ 50% □ 75% □ 100% □ None. If you wish, please explain your answer: ________
   __________________________________________
12. What percentages of the people you associate with engage in illegal activities?
   □ 25% □ 50% □ 75% □ 100% □ None. If you wish, please explain your answer: ________
   __________________________________________

Recovery Support Services

13. Religious preference: □ Christian □ Buddhist □ Catholic □ Other: __________________________

   Are you currently active? □ Yes □ No. If yes, how often? __________________________
14. 12-step or Self-help involvement: □ AA □ NA □ Alnon □ Other: __________________________

   Are you currently active? □ Yes □ No. If yes, how often? __________________________
15. Family support: □ Yes □ No. Please explain your answer: __________________________
16. What services are you applying for? □ Residential □ Outpatient □ Not Sure
17. Living Arrangements (check one): □ Homeless □ Living with Family/Friends □ Living Alone
   How Long? ________. Do you want to improve your living arrangements? □ Yes □ No

Information gathered during the screening process is used to determine eligibility and appropriateness for treatment services rendered by Hina Mauka.
Additional information may be required by Hina Mauka to make an appropriate recommendation for treatment. I, the client, understand that the information
provided does not constitute admission into treatment and that more information may be needed to accurately determine eligibility and appropriateness for
treatment services. I, the client, also understand it will be my responsibility to attain all documents and information needed to determine eligibility and
appropriateness. Hina Mauka may assist in the process; however, the primary responsibility to attain additional information will be the client. Hina Mauka has
the right to determine a client inappropriate for our services. By signing below, I agree that the information provided on this form to be accurate and true to the
best of my knowledge.

________________________________________ __________________________
Client Signature Date

________________________________________ __________________________
Staff Signature Date

Page 4-Section 1
COVID-19 Screening Questionnaire

Name: ___________________________ Date: ___________ Temp: ___________

COVID-19 SCREENING QUESTIONNAIRE

1. Have you previously been tested for COVID19? □ Yes □ No
   If yes, when? __________________ & where? __________________ Results: □ Negative □ Positive
2. Have you traveled outside of Hawaii in the past 14 days? □ Yes □ No
   If yes, dates/location traveled: ________________________________
3. Have you come into contact with any individual that has traveled outside of the Hawaii in the past 14 days?
   □ Yes □ No
   If yes, dates/location traveled: ________________________________
4. Have you had contact with any individual with cold or flu-like symptoms? □ Yes □ No
5. In the last 14 days have you or anyone in your household have close contact with a person who has tested positive for the COVID-19? □ Yes □ No
6. In the last 14 days have you or anyone in your household have close contact with a person who has been instructed to self-isolate, self-monitor or self-quarantine? □ Yes □ No
7. Have you experienced any of the following in the past 14 days?
   a. Fever □ Yes □ No
   b. Chills □ Yes □ No
   c. Body/muscle aches □ Yes □ No
   d. Malaise/fatigue □ Yes □ No
   e. Headache □ Yes □ No
   f. Cough □ Yes □ No
   g. Sore throat □ Yes □ No
   h. Runny nose □ Yes □ No
   i. Swollen lymph glands □ Yes □ No
   j. Nausea, vomiting, diarrhea □ Yes □ No
   k. Shortness of breath □ Yes □ No
   l. Loss of taste or smell □ Yes □ No
   m. Repeated shaking with chills □ Yes □ No

8. Have you recently sought medical attention in a Hospital, Emergency Room, Urgent Care, or Primary Care Provider's office?
   □ Yes □ No
   If yes, date seen: _____________________ & reason for seeking care: _____________________
COVID-19 PANDEMIC IMPACT STATEMENT

1. Have you recently experienced employment/business hardship as a result of the COVID-19 pandemic?
   - No
   - Yes. If yes, please explain: _________________________________________________
     _________________________________________________
     _________________________________________________

   Last date range of employment? From: ________________ To: ________________
   Would you be interested in receiving assistance for these hardships? Yes No

2. Have you experienced any mental, physical health problems or increase in alcohol and/or substance use as a result of the COVID-19 pandemic?
   - No
   - Yes. If yes, please explain: _________________________________________________

   Would you be interested in receiving services for these issues? Yes No

3. If available, would rental/mortgage/financial assistance for you or a household member be helpful at this time?
   - No
   - Yes. If yes, please explain: _________________________________________________

(Eligible participants must complete the necessary requirements to receive rental/mortgage/financial assistance. Please see Rental Relief Housing Assistance Program Requirements)

Print Name: __________________________ Date: ________________

Signature: _____________________________

***I acknowledge by my signature that the above information I provided to be accurate and true.***
Consent to Obtain/Disclose Confidential Information
Third Party Payor (Health Insurance)

I, ____________________________________________, authorize

(Print name of client)

Hina Mauka to obtain/dISCLOSE to________________________________________

(Medical Insurance Company/Agency/Office)

Nature of information to be disclosed: (information disclosed should be relative to the purpose of disclosure)

Client Initial:
____ Name and other identifying information (e.g., DOB, client #, and address)
____ Medical, Psychiatric including my substance abuse information relevant to the current treating condition
____ Progress in treatment, discharge planning and summaries related to the treating condition
____ Scheduled treatment dates to include; appointments, missed and attended treatment dates
____ Appeals: I hereby grant Hina Mauka the right to appeal on my behalf in cases that my medical provider denies
my coverage
____ Other: ______________________________________________________________________________

The purpose of the disclosures authorized in this consent is for: Provide medical, psychiatric including substance
abuse information for the purpose of attaining insurance authorization relevant to the treating condition.

I understand that my substance abuse disorder and treatment records are protected under the Federal regulations
governing Confidentiality and Drug Abuse 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 by the regulations. I also understand that I may revoke this consent in writing at any
time except to the extent that action has been in reliance on it, and that in any event this consent expires automatically
as follows:

I year from discharge date
(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment,
or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure
for other purposes.

I have been provided a copy of this form.

Date: ___________________ __________________________

(Signature of client) (Signature of person signing consent if not client)

Describe authority to sign on behalf of client: ______________________________________________________

PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.
Consent to Obtain/Disclose Confidential Information
Non-Treating Provider Entity (Legal, Representative)

I, ________________________________________________________________, authorize
(Print name of client)

Hina Mauka to obtain/disclose to _______________________________________
(Representing Agency/Entity. One consent per agency/entity)

(Representative Name(s): PO, PD or other. If more than one name, list them on this line.)

Nature of information to be disclosed: (information disclosed should be relative to the purpose of disclosure
Client Initial:
____ Full Name
____ Treatment Attendance, (to include dates)
____ Treatment Progress to include my substance abuse information (periodic reports as required)
____ Legal and/or Criminal History (is applicable)
____ Discharge Planning and Summaries including my substance abuse information (consultation and reporting)
____ Other ______________________________________________________________

The purpose of the disclosures authorized in this consent is for: Consultation on behalf of the client’s substance
abuse/mental health treatment relative to the treating condition.
I understand that my substance abuse disorder and treatment records are protected under the Federal regulations
governing Confidentiality and Drug Abuse 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 by the regulations. I also understand that I may revoke this consent in writing at any
time except to the extent that action has been in reliance on it, and that in any event this consent expires automatically
as follows:

1 year from discharge date
(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if
permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Date: ________________________________
(Signature of client)

(Signature of person signing consent if not client)

Describe authority to sign on behalf of client: ______________________________________________________________

PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any
further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available
information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual
whose information is being disclosed 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 (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance
use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

Client Name: ______________________
Date: ________________________________
Consent to Obtain/Disclose Confidential Information  
Family-Relatives-Supporters (Support Systems)

I, ______________________________________________________________, authorize

(Print name of client)

Hina Mauka to obtain/disclose to________________________________________

(Full name of family/relative. One per consent)

Nature of information to be disclosed:
Client Initial:
_____ Name and other identifying information (e.g., DOB, client #, and address)
_____ Progress in treatment, discharge planning and summaries related to the treating condition
_____ Scheduled treatment dates to include; appointments, missed and attended treatment dates
_____ Other: ______________________________________________________________________________

The purpose of the disclosures authorized in this consent is for: **Encouraging support for the client prior to treatment, during treatment and after treatment.**

I understand that my substance abuse disorder and treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse 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 by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been in reliance on it, and that in any event this consent expires automatically as follows:

1 year from discharge date
(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Date: ___________________  
(Signature of client)

(Signature of person signing consent if not client)

Describe authority to sign on behalf of client: ______________________________________________________________

PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

Rev: 9.29.20   □ Input into WIC 2

Client Name: _______________________

Date: ___________________
Consent to Obtain/Disclose Confidential Information
Treating Provider Entity (Other treating agencies)

I, ______________________________________________________________, authorize

(Print name of client)

Hina Mauka to obtain/disclose to ________________________________________

(Doctor, Psychiatrist, Psychologist, treatment agency, etc. One consent per agency)

Nature of information to be disclosed: (information disclosed should be relative to the purpose of disclosure

Client Initial:

____ Full Name

____ Diagnosis, evaluation, assessment and treatment recommendations including substance abuse information

____ Treatment Attendance, (to include dates)

____ Treatment Progress (periodic reports as required)

____ Legal and/or Criminal History (is applicable)

____ Discharge Planning and Summaries (consultation and reporting) including substance abuse information

____ Other ________________________________________________________________

The purpose of the disclosures authorized in this consent is for: Consultation on behalf of the client’s substance abuse/mental health treatment relative to the treating condition.

I understand that my substance abuse disorder and treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse 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 by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been in reliance on it, and that in any event this consent expires automatically as follows:

I year from discharge date

(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Date: ___________________ ______________________________

(Signature of client) (Signature of person signing consent if not client)

Describe authority to sign on behalf of client: ________________________________________________________________

PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.