HINA MAUKA

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 (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.