



# HINAMAUKA

## Consent to Obtain/Disclose Confidential Information Applicant Consent to Authorize a Representative to Complete The Screening Application

I, \_\_\_\_\_, authorize  
*(Print name of client)*

**Hina Mauka** \_\_\_\_\_ to obtain/disclose to \_\_\_\_\_  
*(Representing Agency/Entity. Individual. One consent per agency/entity)*

\_\_\_\_\_  
*(Representative Name(s): PO, PD or other. If there is 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:

- \_\_\_\_\_ 1. Completed Screening Application (Online or paper). Application needs to be fully completed. Delays may occur if the application is incomplete.
- \_\_\_\_\_ 2. Pdf or jpg copy of the applicant's identification
- \_\_\_\_\_ 3. Current Physical and TB test (residential only)
- \_\_\_\_\_ 4. Other medical or psychiatric information as appropriate.

The purpose of the disclosures authorized in this consent is for: **Provide sufficient client information to conduct a case review to determine eligibility and appropriateness for Hina Mauka treatment services.**

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:

***Date of Discharge***  
*(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 with 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.