1787 Wili Pa Loop, #7
Wailuku, HI 96793
Phone (808) 249-2121| Fax (808) 249-8920

Consent for the Release and Exchange of Confidential Information

As protected by and provided for in Federal Law 42 CFR Part 2

By signing this form, you authorize Maui Counseling Group (a division of Aloha House, Inc.) to release or exchange otherwise confidential psychological information to people or agencies whom you designate.

I authorize Maui Counseling Group to (Check all that apply):

- ☐ Verbally discuss otherwise confidential information related to my behavioral health/mental health therapy
- ☐ Transmit a copy of my otherwise confidential Private Health Information (PHI), which includes behavioral/mental health service information including medication prescription and monitoring, counseling session start and stop times, modalities and frequencies of treatment, results of clinical tests, and any summary of the following items: Diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.)
- ☐ Send a copy of my otherwise confidential psychotherapy notes (the most detailed record of the conversations between my therapist and me and/or members of joint or family sessions)
- ☐ Send a letter or treatment summary containing my otherwise confidential health information regarding my behavioral health/mental health treatment
- ☐ Other (please specify)_____
- ☐ I agree to the release of the following information should it be contained in my medical record: AIDS/HIV status, alcohol and/or drug abuse treatment **(Initial Here: ____)**

I authorize the release of the above information to the following person or agency:

Name:	**Address:**

I authorize this Release of Information for the following purposes:

☐ Coordination of Services	☐ Treatment Planning
☐ Contact with my referral source	☐ Litigation
	☐ Other_____

Restrictions on this Release – check those that apply:

- ☐ I authorize ongoing communication until I revoke this consent.
- ☐ I authorize only specific information (please describe)_____
- ☐ I authorize communication only until this date_____
- ☐ I DO NOT agree to the release of HIV/AIDS status or alcohol/drug abuse information (circle those that apply). I understand that my record will be marked as "redacted" and information regarding my status will be removed.

*I understand that I **do not** have to agree to release confidential information except as required by law or under the requirements of my insurance policy (as detailed in the MCG Notice of Privacy Practices), and that I may withdraw this consent at any time except insofar as action has already been taken. A fax of this form is as valid as the original.*

Client Name (printed)_____ Client Date of Birth_____

Client Signature_____ TODAY'S DATE_____

For Office Use: If client is not personally known to MCG, client's identity was verified by:

- ☐ Driver's License (specify type and number)_____ Other Photo ID_____
- ☐ Office Staff Signature and title_____

Revised 1/2014