North Shore Mental Health
Adult Mental Health Division
AUTHORIZATION TO *RELEASE/OBTAIN* CONFIDENTIAL INFORMATION

NAME OF CONSUMER: ____ BIRTHDATE: ______/______/________

I, ____ hereby agree that North Shore Mental Health may

Release/Obtain information about me/consumer from the following organization(s) or individual(s):

___Dept. of Health, State of Hawaii

___Other:______________________________ ____
(name) (address, city, state, zip)

This information includes:

1) substance use information: yes ☐ not applicable ☐ __________________ (person's initials)

2) HIV/AIDS information: yes ☐ not applicable ☐ __________________ (person's initials)

*If either of the above information is to be released/obtained, specific benefits, risks, and alternatives need to be addressed.

Purpose for information:

Specific information requested:

Benefits: Assist in treatment planning and service coordination

Risk: Confidential information may be shared

Alternative: Not to release information

Date event / condition upon which this consent expires: ____

The form in which this information will be shared: written ☐ verbal ☐ (check appropriate box)

For the person(s) providing consent:
- -This consent has been made freely, voluntarily and without coercion
- -I was able to ask questions and receive answers about this release
- -I hereby authorize obtaining the information as specified above and further understand that
  - *Those who receive this information cannot disclose it to others without my further consent, unless permitted by Federal or State law
  - *I may withdraw this consent anytime before the information is released

Name of person(s) providing consent:	Relationship to consumer:
Signature(s) of person(s) providing consent:	Date:
Signature and title of staff obtaining consent:	Title:

Revised 11/02