Serenity
Counseling Services Hawaii
Peace Through Knowledge

Serenity Counseling Services
& All Associated Providers
Authorization of Disclosure of Protected Health information

Name_____ DOB:_____ SSN_____

By signing this form, I am allowing Serenity Counseling Services Hawaii and its Associated Providers to:

☐ Release to; ☐ Obtain From; ☐ Exchange with;

Name/Entity: _____

Address: _____

City, State Zip Code: _____

Phone: _____ FAX: _____

Written or oral information indicated below by telephone, fax, electronic data exchange or mail:

☐ My complete medical record

All items checked here:

☐ Psychiatric Evaluation	☐ Laboratory Results	☐ Psychological History
☐ Psychological Assessment	☐ Psychological Testing	☐ Initial Assessments
☐ Medical Progress Notes	☐ Initial Assessment	☐ Discharge Summaries
☐ Counseling Notes	☐ Appointment Information	☐ Treatment Summary
☐ Treatment Plan(s)	☐ Medical History	☐ Billing Information

☐ Other (Specify): _____

Please indicate the reason for release:

☐ Continuity of Care Rehab/Disability ☐ Legal ☐ Insurance ☐ Transferring Care

☐ Other: (Please Specify): _____

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to: Medical Records, Serenity Counseling Services, 99-149 Maonolua Rd, Aeia HI 96701 FAX: 808-468-2439. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Medical Records at the above address.

Confidentiality of the information is protected by Federal Law (42-CFR-Part 2) and the code of Hawaii. Further disclosure is prohibited without specific consent from whom it pertains. General authorization is not sufficient for this purpose.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

As an integrated provider organization, I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

_____Substance Abuse _____Mental Health _____HIV-related information _____Genetic tests/info

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____. (See back for additional information about this consent).

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

Signature of Patient/Guardian_____ Date_____

Signature of Staff or Witness_____