



Authorization to Use and Disclose Confidential Information/Protected Health Information

Name: _____ DOB: _____

I, hereby authorize WorkLife Hawaii, a program of Child & Family Service (CFS) to use and disclose the following confidential health information.

Specific information: _____

RELEASE (Send information – Use and Disclose)

The purpose to RELEASE this information is _____

I authorize _____ (specific person or persons) to use and disclosure RELEASE my confidential information to:

Individual/Agency/Organization

OBTAIN (Request Information – Use and Disclose)

The purpose to OBTAIN this information is _____

I authorize _____ (specific person or persons) to use and disclose OBTAIN my confidential information from:

Individual/Agency/Organization

I further authorize the release of:

1) Substance use information:

Yes _____

No _____

Not applicable _____

2) HIV/AIDS information:

Yes _____

No _____

Not applicable _____



Authorization to Use and Disclose Confidential Information/Protected Health Information (Continued)

*Protected Health Information includes any and all information contained in the case record related to the client, including identifying information such as date of birth, name, etc.

If the above information is to be released or obtained, these are the specific benefits, risks and alternatives:

- Materials may be shared in any of the following manner, unless otherwise specified: written, mailed, facsimile, electronically transferred (E-mail, computer diskette), or verbally.
- This authorization has been made freely, voluntarily and without coercion.
- I was able to ask questions and receive answers about this release.
- WorkLife Hawaii/CFS may not condition treatment or provision of services on whether I sign or do not sign this authorization.
- The information used or disclosed by this authorization may be subject to redisclosure by the recipient and no longer be protected unless prohibited by Federal or State Law.
- I understand that I have the right to revoke (withdraw) this authorization in writing, except I cannot revoke this authorization for information that has already been disclosed subject to the authorization. Please refer to the WorkLife Hawaii/CFS "Notice of Privacy Practices". I may submit such a written request to revoke authorization to my worker.

I understand this Authorization will expire when services are terminated; when I withdraw from services; when I withdraw this Authorization in writing; or one-year from this date.

Name: _____
(Please print)

Name: _____
(Please print – Parent, Legal Guardian of minor)

Signature: _____

Signature: _____

Date: _____

Date: _____

Witnessed by: _____
(Staff Name and Title)

Date: _____