Samaritan Counseling Center Hawaii

Release of Information Consent Form (Optional)

For clients who choose to authorize SCCH to communicate with a family member, caregiver, doctor, agency, hospital, treatment facility, Court/Judiciary, or other third-party.

I, (Client Name) _____, hereby give my permission for the following releases of information by my therapist at the Samaritan Counseling Center Hawaii:

Name of Counselor: _____

Check the options that apply:

- ❑ To schedule, re-schedule, or confirm appointments
- ❑ To release information to ❑ or request information from ❑ the following person/s:

Name of agency, hospital, doctor, or therapist: _____

Mailing Address: _____
Street City State Zip

_____
Telephone Fax email

The items covered by this release are checked below:

- ❑ Appointments and Cancellations
- ❑ Progress Notes and Treatment Plan
- ❑ Psychological Evaluation
- ❑ Other: _____

This information is being released for the following reasons:

_____

❑ I understand that this release may include information regarding drug and alcohol abuse and treatment, as well as psychological and psychiatric information.

❑ I understand that the information to be released is protected under state and federal laws that do not permit re-disclosure without my further consent.

❑ I understand that I may revoke this authorization at any time, except for information that has been disclosed as a result of this authorization prior to its revocation.

❑ This consent will expire _____ days from the date it is signed.

_____ _____
Signature of Client, Parent, Guardian, or Authorized Representative Date

_____ _____
Signature of Witness Date