KAPI'OLANI COMMUNITY COLLEGE

CONSENT FOR RELEASE OF INFORMATION OR RECORDS

I HEREBY AUTHORIZE
(name of person sending the information):

_____
Name

_____
Organization

_____
Address

_____
City State Zip Code

_____
Phone/fax Email

TO BE RELEASED TO
(Name of receiving person, agency, or institution):

_____
Name

_____
Organization

_____
Address

_____
City State Zip Code

_____
Phone/fax Email

Information (including counseling/psychotherapy, medication, psychiatric/psychological assessment, testing, recommendations, and relevant medical information and lab reports), pertaining to the care and treatment of:

Name:_____ Date of Birth: _____ Student No.:_____

This consent includes the release of any or all records pertaining to:

Initials
( ) Alcohol and/or drug abuse treatment
( ) Mental Health & Psychiatric Care/Assessment
( ) A condition related to a sexually transmitted disease including human immunodeficiency virus (HIV)

_____ I understand such information cannot be released without my specific consent.
Initials

_____ Disclosure is authorized for the following report(s)/information only:
Initials _____

_____ Disclosure of the record(s)/information may be used only for the following purposes:
Initials _____ Continuing Care
_____ Other (specify)_____

I have read this authorization and I understand it. Unless revoked, in writing, this authorization will expire in one year OR _____ (specify date). If I fail to specify an expiration date or event this authorization will expire 360 days from the date it was signed. I understand that consent may be revoked at any time by written request, and that not signing this authorization will not adversely affect my ability to receive services. I have read and initialed that I understand the information below regarding "redisclosure".

_____ _____
Date Signature of Student or Authorized Representative

_____
Signature of Kapi'olani Community College Representative

*****Redisclosure Information-please initial after reading

_____ I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of the information because some information is not protected under federal or state law. However, I also understand that federal or state law may restrict the redisclosure of HIV/AIDS, mental health, and drug/alcohol diagnosis/treatment/referral information, as specified previously on this form. Kapi'olani Community College, Ka'au Program will not re-dislcose any information received from another party unless authorized by the student.