Akahai Counseling LLC
284 Front St. Lahaina, HI 96761
808-205-0374

CONSENT FOR RELEASE OF INFORMATION

Client Information:
Name: Last Name______________________ First Name ____________________ Date of Birth: ___________
Address: ____
Phone: __________________

Recipient Information

I, __________________________, do hereby authorize Akahai Counseling LLC to release documents/information to the person or facility below:

Name of person/facility: ____
Phone: ____
Address: ____

Date of Authorization: __/___/____
Authorization will expire on __/___/____ or upon the following event: ____________________________

Information to be released:

Purpose of the Information released:

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Print name: _______________________________________ Phone: ______________________

Signature: ____ Date: _______________________

If signed by a personal representative: Please initial to indicate your relationship to the client and legal authority for signing.

Patient is: ___minor ___incompetent ___disabled ___deceased
Legal authority: ___parent ___legal guardian ___ representative of the deceased