Aloha Counselors, LLC

Laura E. Williams, LMHC, CSAC, PhD

1325 S. Kihei Road - Suite 205

cell: 860.306.6118 fax: 808.214.6090

Release of Confidential Information

I _____ authorize Laura E. Williams, LMHC, CSAC, PhD to talk and correspond with _____about the reasons for my referral, any relevant history or diagnoses, and other similar information that can assist with my receiving treatment or being evaluated or referred elsewhere.

Voluntary: This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

In Compliance: This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502); and pursu-ant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization). This form is to serve as both a general authorization, and a special authorization to release information under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), the Comprehensive Alcohol Abuse and Alcoholism Pre-vention, Treatment and Rehabilitation Act Amendments of 1974 (Public Law 93-282), the Veterans Omnibus Health Care Act of 1976 (Public Law 94-581), and the Veterans Benefit and Services Act of 1988 (Public Law 100-322). It is also in compliance with 42 C.F.R. Part 2 (Public Law 93-282), which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations. It is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191.

Release of Liability: In consideration of this consent, I hereby release the source of the records and Laura E. Williams from any and all liability arising there-from.

No Obligation: I understand that no services will be denied me/the patient solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan for me/the patient. The information disclosed may be used in connection with my/the patient's treatment.

_____ _____ _____

Signature of client Printed name Date

I, a mental health professional, have discussed the issues above with the patient and/or his or her parent or guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____ _____

Signature of professional Printed name Date

❑ Copy for patient or parent/guardian ❑ Copy for source of records ❑ Copy for recipient of records