Alcohol and Drug Abuse Division (ADAD)
Authorization to Jointly Disclose Protected Health Information (PHI)
Coordinated Addiction Resource Entry System (CARES) for Substance Use Disorder (SUD) Services
CARES Network Consent Form (Required for SUD Services)

Individual Whose Protected Health Information is Being Disclosed
First Name: ____________________ **Last Name:** ____________________
Address: ____________________ **Birth Date:** ____________________

FROM: Alcohol and Drug Abuse Division
601 Kamokila Boulevard, Room 360, Honolulu HI 96707
FROM: All Parties Identified within the CARES provider network

TO: All Parties Identified within the CARES provider network
TO: Alcohol and Drug Abuse Division
601 Kamokila Boulevard, Room 360, Honolulu HI 96707

☐ **I authorize disclosure of my Protected Health Information to any agencies within the CARES provider network, for the purpose of care coordination, treatment, and service provision, as listed on the ADAD website http://health.hawaii.gov/substance-abuse/.**

I authorize that the following Protected Health Information be disclosed: Any and all information relevant to substance use pre-treatment, pre-recovery, treatment, recovery, care coordination, health and wellness plans, interim care, continuing care, assessments and support services. This includes but is not limited to:

☐ All health information (e.g., diagnosis, test results, treatment); OR

☐ Images and/or Films ☐ Reports ☐ Billing ☐ Dental

☐ HIV/AIDS Test Result — Initial here ____

☐ Drug and Alcohol Treatment (e.g., diagnosis, test results, treatment, billing, attendance) — Initial here ____

☐ Mental Health (e.g., diagnosis, test results, treatment, billing) — Initial here ____

☐ Other: ____________________) — Initial here ____

The Protected Health Information is being disclosed for the following purpose: **To help identify the client's needs and strengths, assist in developing treatment recommendations, assist in screening of eligibility for services and to provide care coordination of substance use disorder services.**

This authorization will be in force and effect until: **<u>One Year</u> after Termination of Services**. At that time, this authorization to disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Department of Health. I understand that a revocation is not effective to the extent that the Department has relied on the disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that certain information disclosed pursuant to this authorization may be disclosed by the recipient (e.g., HIPAA or mandated reporting). However, I understand that any information related to education (FERPA 34, CFR Part 99), alcohol or drug treatment services (42 CFR Part 2) may not be disclosed or re-disclosed without my authorization.

The Entity or Person(s) receiving this information will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested disclosure.

I understand the information provided may be used in a de-identified form for research and, audit and system evaluation purposes.

The disclosure requested under this authorization will result in direct or indirect remuneration to the Department from a Third Party. I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, healthcare operations or eligibility for benefits, as permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

(Check this box ONLY if the disclosing party will receive compensation or other benefit when using or disclosing this Protected Health Information). ☐

Individual or Personal Representative Signature: ____________________ Date: ____________________

Print Name of Individual or Personal Representative: ____________________ Description of Personal Representative's Authority ____________________

ID: ____________________