



## Family Tree Project, LLP

### Authorization to Release/Obtain Information

I, \_\_\_\_\_ hereby agree that the Family Tree Project, LLP,  
\_\_\_\_\_ Release \_\_\_\_\_ Obtain (client/parent /legal guardian initials on line) information about me, the

consumer, to/from the following individual:

From/To: Youth Challenge Academy  
1787 Shangrila St.  
Kapolei, HI 96707  
Phone: (808) 673-7530

The form in which this information will be shared (check appropriate): \_\_\_\_\_ Written \_\_\_\_\_ Verbal \_\_\_\_\_ Phone

#### For the person(s) providing consent

This consent has been freely, voluntarily and without coercion.

I was able to ask questions and receive answers about this release.

I hereby authorized obtaining the information as specified above and further understand that: Those who receive this information cannot disclose it to others without further consent, unless permitted by Federal or State law.

I also understand that I may revoke this consent at any time either verbally or in writing, except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows:

\_\_\_\_\_  
(Specification of the date, event or condition upon which this consent expires)

Consent expires on this day (check one): \_\_\_\_\_ One year from signing \_\_\_\_\_ Other Date: \_\_\_\_\_  
(Consent cannot be of greater length than one year)

\_\_\_\_\_  
Print name of client providing consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of client providing consent

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Signature of Staff/Agency Witness

\_\_\_\_\_  
Title of Witness

\_\_\_\_\_  
Date

This consent is withdrawn effective \_\_\_\_/\_\_\_\_/\_\_\_\_

Withdrawal requested: \_\_\_\_\_ Verbally \_\_\_\_\_ In Writing

Signature of Client: \_\_\_\_\_

\*Original copy to Client's file (Family Tree Project)

\*Copy to Provider(s)/client



## Family Tree Project, LLP

### Initial Client Information

Parent Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Child(ren) Names: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Insurance Information:

Policy holder: \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Insurance ID: \_\_\_\_\_ Policy holder Birthdate: \_\_\_\_\_

Has anyone in your family been in treatment before? \_\_\_\_\_

If so, who, where and when? \_\_\_\_\_

**Please print legal name clearly:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_



## Family Tree Project, LLP

### HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

#### **Understanding Your Protected Health Information (PHI)**

When you visit us, a record is made of your symptoms, examinations, test results, diagnoses, treatment plan, and other mental health or medical information. Your record is the physical property of the mental health care provider. The information within belongs to you. Being aware of what is in your record will help you to make more informed decisions when authorizing disclosures to others. In using and disclosing your PHI, it is our objective to follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act (HIPAA) and requirement of state law.

#### **Your Mental Health and/or Medical Record Serves as:**

- A basis for planning your care and treatment.
- A means of communication among the health professionals who may contribute to your care.
- A legal document describing the care you received.
- A means by which you or a third party payer can verify that services billed were actually provided.
- A source of information for public health officials charged with improving the health of the nation.
- A source of data for facility planning and marketing.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

#### **Responsibilities of (Family Tree Project, LLP)**

We are required to:

- Maintain the privacy of your PHI as required by law and provide you with notice of legal duties and privacy practices with respect to the PHI that we collect and maintain about you.
- Abide by the terms of this notice currently in effect. We have the right to change our notice of privacy practices and to make the new provisions effective for all protected health information that we maintain, including that obtained prior to the change. Should our information practices change, we will post new changes in the reception room and provide you with a copy.
- Notify you if we are unable to agree to a requested restriction.
- Use or disclose your health information only with your authorization except as described in this notice.



## Family Tree Project, LLP

### **Your Protected Health Information (PHI) Rights**

You have the right to

- Review and obtain a paper copy of the notice of information practices and your health information upon request. A few exceptions apply. Copy charges may apply.
- Request and provide written authorization and permission to release PHI for purposes of outside treatment and health care. This authorization excludes psychotherapy notes and any audio/video tapes that may have been made with your permission for training purposes.
- Revoke your authorization in writing at any time to use, disclose, or restrict health information except to the extent that action has already been taken.
- Request a restriction on certain uses and disclosures of PHI, but we are not required to agree to the restriction request. You should address your restriction in writing to the Privacy Officer by asking for the name of Privacy Officer, address, and phone. We will notify you within 10 days if we cannot agree to the restriction.
- Request that we amend your health information by submitting a written request with reasons supporting the request to the Privacy Officer. We are not required to agree with the requested amendment.
- Obtain an accounting of disclosures of your health information for purposes other than treatment, payment, health care operations, and certain other activities for the past six years but not before April 14, 2003.
- Request confidential communications of your health information by alternative means or at alternative locations.

### **Disclosures for Treatment, Payment, and Health Operations**

Family Tree Project, LLP will use your PHI, with your consent, in the following circumstances:

Treatment: Information obtained by a nurse, physician, psychologist/counselor, dentist, or other member of your health care team will be recorded in your record and used to determine the management and coordination of treatment that will be provided for you.

Disclosure to others outside the agency: If you give us written authorization, you may revoke it in writing at any time but that revocation will not affect any use or disclosures permitted by your authorization while it was in effect. We will not use or disclose your health information without your authorization, except to report a serious threat to the health or safety of a child and/or vulnerable adult.

For payment, if applicable: we may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis to obtain reimbursement for your health care or to determine eligibility or coverage.



## Family Tree Project, LLP

For health care operations: Members of the mental health staff or members of the quality improvement team may use the information in your health record to assess the performance and operations of our services. This information will be used in an effort to continually improve the quality and effectiveness of the mental health care and services we provide.

We may use or disclose your PHI in the following situations without your authorization: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse/neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners and organ donation, research, or workers' compensation. Under the law, we must make disclosures to you when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements.

### **For More Information or to Report a Problem**

If you have questions and would like additional information, please ask your clinician. He/she will provide you with additional information or put you in contact with the designated Privacy Officer. If you are concerned that your privacy rights have been violated or you disagree with a decision we have made about access to your health information, you may contact the Privacy Officer. We respect your right to privacy of your health information. There will be no retaliation in any way for filing a complaint with the Privacy Officer of our agency or the U.S. Department of Health and Human Services.



## Family Tree Project, LLP

### HIPAA Privacy Authorization for Use and Disclosure of Personal Health Information

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations as amended from time to time.

You may refuse to sign this authorization.

By my signature below, I acknowledge that I have received and read the Notice of Health Information Privacy Practices. I have been provided a copy of, read and understand (Family Tree Project) HIPAA Privacy Notice containing a complete description of my rights, and the permitted uses and disclosures of my protected health information under HIPAA. Further, I acknowledge that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and is no longer protected under HIPAA.

Name \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street City State Zip

Date of Birth: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Parent/Guardian Signature (if client under 18) \_\_\_\_\_

#### For office use only

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained.

Reason: \_\_\_\_\_

\_\_\_\_\_  
Clinician Signature Date

Individual HIPAA Provider Number of Clinician Completing Form: \_\_\_\_\_

HIPAA Organization Number of Clinician Completing Form: \_\_\_\_\_



## Consent for Evaluation and/or Treatment

Child Form

Name:

Date of Birth:

1. **Consent to Evaluate/Treat:** I voluntarily consent that my child will participate in a mental health evaluation and/or treatment by staff from Family Tree Project, LLP. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
  - a. The benefits of the proposed treatment
  - b. Alternative treatment modes and services
  - c. The manner in which treatment will be administered

The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Hawaii State Law for Mental Health Counseling. In addition to following the Hawaii Administrative Code, Family Tree Project, LLP, also follows ethics and requirements regulated by the American Counseling Association and the National Board of Certified Counselors.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered through psychological interviews, psychological assessment or testing, and psychotherapy, as well as expectations regarding the length and frequency of treatment. It may be beneficial to my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.
3. **Charges when Applicable\*:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. If fees are applicable, I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees, **when applicable will be agreed upon prior to the service with the responsible party**. Clients have a right to terminate treatment at any time.
4. **Confidentiality, Harm, and Inquiry:** Information from my child's evaluation and/or treatment is contained in a confidential medical record at Family Tree Project, LLP. I consent to disclosure for use by Family Tree Project, LLP, staff for the purpose of continuity of my child's care. Per Hawaii State law, information provided will be kept confidential with the following exceptions: 1) if my child is deemed to present a danger to himself/herself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.
5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.
6. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

\_\_\_\_\_  
Signature of legal guardian for minor under age 18

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date

Note: Hawaii State Law (HRS 577-26e) allows minors of any age who profess to seek treatment for Drug and/or Alcohol abuse without parental consent.