



Assessment Referral Form

Form also available online at: www.lokहितreatmentcenters.net

Date: ____/____/____

Type of service(s) requested: _____

Your Name: _____

Your Contact Number: _____

Client Contact Number: _____

Alternate Client Contact Number (optional): _____

ASSESSMENT CONSENT

Client Name: _____

I hereby authorize Lokahi Treatment Centers to,

Release To and Obtain From: _____
(Your Agency)

The following information:

Screening/Assessment Appointment

The purpose to release or obtain this information is:

To exchange information regarding referral for treatment services.

By signing below, I understand that materials may be shared in any of the following manner, unless otherwise specified: Written, Mail Out, Electrically Transferred (E-mail, Fax), Verbal. Those who receive this information cannot disclose it to others without further consent, unless permitted by State or Federal law. This consent has been made freely, voluntary and without coercion and I was able to ask questions and receive answers about this release. I understand that this consent expires automatically after one (1) year from the date above.

Client Signature: _____

MINOR Parent/Guardian Signature: _____

Witness Signature: _____

HILO Tel: (808) 969-9292 Fax: (808) 969-7337	HONOKA'A Tel: (808) 775-7707 Fax: (808) 775-8009	KOHALA Tel: (808) 889-5099 Fax: (808) 883-1022	KONA Tel: (808) 331-1175 Fax: (808) 327-1809	PAHOA Tel: (808) 965-5535 Fax: (808) 969-7337	WAIKOLOA Tel: (808) 883-0922 Fax: (808) 883-1022
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