Assessment Referral Form

Form also available online at: www.lokahitreatmentcenters.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:
[X] Screening/Assessment Appointment

The purpose to release or obtain this information is:
[X] 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	HONOKA'A	KOHALA	KONA	WAIKOLOA
Tel: (808) 969-9292	Tel: (808) 775-7707	Tel: (808) 889-5099	Tel: (808) 331-1175	Tel: (808) 883-0922
Fax: (808) 969-7337	Fax: (808) 775-8009	Fax: (808) 883-1022	Fax: (808) 327-1809	Fax: (808) 883-1022