Referral Form

Form also available at: www.lokahitreatmentcenters.net

Date: _____/_____/_____

Referral Source *(Name of Agency/Organization)*: _____

Referring Staff Name: _____ **Phone Number:** _____

Legal Name of Client: _____

Address: _____
Street Address, Apt/Suite # *City* *State* *Zip Code*

Home Phone #: _____ **Cell Phone #:** _____ **Work Phone #:** _____

Please Check Services Requested:

[ ] Substance Abuse Treatment **[ ] Mental Health** **[ ] Domestic Violence** **[ ] Anger Management**

[ ] DUI **[ ] Adolescent Referral** **[ ] Other:** _____

CONSENT TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

Name: _____ **DOB:** _____

I hereby authorize Lokahi Treatment Centers to,

Release To: _____

Obtain From: _____

The following information:
[ ] Screening/Assessment Appointment
[ ] Other: _____

The purpose(s) to release or obtain this information is:
[ ] To exchange information regarding referral for treatment services.
[ ] Other: _____

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.

Name *(print)*: _____ **Signature:** _____

Name *(print)*: _____ **Signature:** _____
Parent or Legal Guardian of Minor

Witnessed By *(print)*: _____ **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