Kamehameha Schools

Mālama Ola Behavioral Health Department

AUTHORIZATION TO DISCLOSE INFORMATION

I hereby authorize the provider/individual named below to obtain and disclose diagnosis, treatment, prognosis and other related information regarding my child for the purpose of informing the provision of available supports and modifications in order to help ensure my child's health and safety while participating in a Kamehameha Schools (KS) program.

I authorize disclosure to and among the following KS employees:

School Administrator(s)	Student Health Director
Behavioral Health Specialist	School Nurse
School Counselor/Dean of Students	Residential Life Staff
Other:___________________________	Behavioral Health Manager/Supervisor

I acknowledge that disclosed/obtained information, other than related to a substance use disorder, may be re-disclosed to other KS employees who have a legitimate educational interest.

This authorization shall remain in effect for the duration of treatment or until the child is no longer a student at KS, whichever occurs first. I understand that I can contact my child's healthcare provider to rescind this authorization at any time.

Student:

Printed Name Date of Birth Grade

Provider/Individual Name:

Printed Name Phone Number

Parent/Guardian:

Printed Name Signature Date