Kamehameha Schools

Mālama Ola Behavioral Health Department

Behavioral Health Care Coordination Form

Student's Name:_____ Grade: _____
First Name Middle Initial Last Name

Authorization to Release Confidential Information:

I/We hereby authorize the disclosure/obtainment of any and all Protected Health Information (PHI) regarding my/our child's mental health to Kamehameha Schools (KS). The purpose of the disclosure/obtainment is to allow coordination with KS to support the health, safety, and well-being of my/our child. I understand that information disclosed pursuant to this authorization will be handled confidentially by KS and shared when there is a legitimate educational interest and may no longer be protected by Federal and State Law.

Print Mother/Guardian Name:	Signature Mother/Guardian:	Date:
Print Father/Guardian Name:	Signature Father/Guardian:	Date:

Treatment Information

Date of Student's last appointment:_____

Date of Student's next appointment:_____

Frequency of appointments:_____

Treatment Modalities used: ☐ Psychotherapy ☐ Pharmacotherapy ☐ Both

Current prescribed medication(s) and dosage: _____

Recommendation regarding ongoing care:

- ☐ Continuing treatment is not necessary at this time.
- ☐ Student will remain under my care.
- ☐ Student is being referred to another treatment provider: _____

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Recommendations to support student in school setting:

_____

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Licensed Mental Health Professional Completing This Report

Name of Mental Health Professional: _____

Are you currently licensed in Hawai‘i? ☐ No ☐ Yes License Number: _____

- ☐ Clinical Social Worker (LCSW)
- ☐ Marriage & Family therapist (LMFT)
- ☐ Mental Health Counselor (LMHC)
- ☐ Psychiatrist
- ☐ Psychologist

Business Address: _____

Phone Number: _____ Fax Number: _____

Clinician’s Signature: _____ Date: _____