KAUAI POLICE DEPARTMENT
3990 Kaana Street, Suite 200
Lihue, HI 96766-1268

PERMIT TO ACQUIRE OBNOXIOUS SUBSTANCE

CHAPTER 22, ARTICLE 15, KAUAI COUNTY CODE 1987

Name:		Social Security Number:
Address:		
Phone Number:	Date of Birth:	Place of Birth:
Sex:	Height:	Weight:

Please Answer the Following Questions

		Yes	No
1.	Are you a fugitive from justice?	☐	☐
2.	Are you under indictment for, or have you waived indictment for, or have you been convicted in this State, or elsewhere of having committed a felony or any crime of violence, or an illegal sale of any drug.	☐	☐
3.	Have you been under treatment or counseling for addiction to, abuse of, or dependance upon any dangerous, harmful, or detrimental drug intoxicating compound, or intoxicating liquor ad defined in HRS Section	☐	☐
4.	Have you been committed due to developmental disabilities or mental Retardation pursuant to HRS Section 333F-9 of 333F-10?	☐	☐
5.	Have you ever been acquitted of a crime on the grounds of mental disease, disorder, of defect pursuant to HRS Section 704-411?	☐	☐
6.	Are you currently or have been under the diagnosed as having a significant behavioral, emotional, or mental disorder as defined by the American Psychiatric Association or for treatment for organic brain syndromes?	☐	☐

7.	Are you currently or have been restrained pursuant to an order of any court from contacting, threatening, or physically abusing any person?	☐	☐
8.	If you are under the age of twenty-five years old, have you ever been adjudicated by the family court to have committed a felony, two or more crimes of violence, or illegal sale of any drugs?	☐	☐

Explanation of any "Yes" Answers:

NOTE:

Hawaii Revised Statues, Section 134-17(a): Any person who gives false information or offers false evidence from his/her identity in complying with any of the requirements of this document, shall be guilty of a misdemeanor, providing, however that if any person intentionally gives false information or offers evidence concerning their psychiatric or criminal history in complying with any of the requirements of this part, that person shall be guilty of a class C felony.

I certify that the answers to the foregoing questions are true and accurate to the best of my knowledge.

_____ _____

Signature Date

FOR KPD USE ONLY

Mental Health Check: _____ Approved: _____

Criminal History Check: _____ Date: _____

Restraining Order Check: _____

KPD FORM 528

Authorization for Use or Disclosure of Protected Health Information (PHI)

Organization Disclosing PHI	Name of Individual/Organization (Other than AMHD) Disclosing PHI
Name: State of Hawaii Adult Mental Health Division (AMHD) PO Box 3378 Honolulu, HI 96801-3378	Name:

Organization That Will Receive the Individuals PHI
Kaua`i Police Department 3990 Kaana Street, Suite 200 Lihue, HI 96766

Client/Patient Whose PHI is being Requested	
First Name:	Last Name:
Address:	Birthday:
	Social Security Number:

I, Authorize that the Following Health Information be Used/Disclosed: (Please Initial Below)

_____ Mental Health _____ Substance Abuse Treatment and/or Counseling

The Protected Health Information is Being Used or Disclosed for the Following Purpose (At the request of the Individual is an acceptable purpose of the request made by the individual and the individual does not want to state specific purpose)

To determine my qualifications to own, possess, or control any firearm or ammunition.

Authorize Duration (The authorization will be in force and effect until the event specified below. At that time, this authorization to use or disclose this protected health information expires).

Expiration of Authorization Event That Relates to the Purpose of the Use or Disclosure:

My disqualification from owning, possessing, or controlling any firearm or ammunition.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the above stated county police department. I understand that a revocation is not effective to the extent that the county police department has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. However, I understand that information related to education (FERPTA, 34 CFR, Part 99), alcohol or drug treatment services (42 CFR Part 2) may not be re-disclosed without my authorization.

Signature:	Date:
Print Name:	