Print Form

INTOXICATED DRIVER RESOURCE CENTER

RECORDS RELEASE AUTHORIZATION

I hereby consent to the release from my records of the information specified below. 10:162-4.6 H.

Name of Client	Driver License Number

The purpose for this release is to communicate with and disclose to one another the following information: to report compliance with the Intoxicated Driving Program, or for any purpose authorized under N.J.S.A. 39:4-50 and other Motor Vehicle Commission and Division of Addiction Services statutes and regulations.

The agencies authorized to make the release are:

- [x] The New Jersey Motor Vehicle Commission;
- [x] The New Jersey Division of Addiction Services;
- [x] The sentencing court;
- [x] Any Intoxicated Driver Resource Center;
- [ ] Attorney, if applicable;
- [x] Corner House (indicate treatment agency/provider);
- [ ] Other: _____

The kind and amount of information to be released are only those records necessary for compliance/non-compliance reports regarding completion with IDRC requirements to complete sentencing or program requirements.

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from my proceedings with the IDRC.

To the recipient of this information:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Name of Client or Person Authorized by Law to Give Consent	Signature	Date
Witness:	Signature	Date

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INTOXICATED DRIVER RESOURCE CENTER

CLIENT SELECTION OF AFFILIATE

Name of Client	County IDRC
	Mercer

I am a client of the Intoxicated Driver Resource Center of the above-named county or regional program, and have been referred to additional assessment, education or treatment for completion of my IDRC program requirements.

This statement is to certify that a list of approved treatment providers has been shown to me and that I selected the following program:

Name of Treatment Program	Corner House

At no time was I pressured or coerced by IDRC personnel to choose one treatment program over another. (If a counselor or IDRC staff person recommended any of the treatment programs on the approved list, please indicate the reason for the recommendation):

_____

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside this program that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless:

1. **The patient consents in writing**
2. **The disclosure is allowed by court order**
3. **The disclosure is made to medical personnel in a medical emergency or to a qualified personnel for research, audit, or program evaluation.**

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

Signature of Client	Date
Signature of County IDRC Representative	Date

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Intoxicated Driver Resource Center

Agreement to Schedule an Appointment for a Complete ASAM-PPC-2-R Assessment

Name and Address of Treatment Program	Name of Client
Corner House 1 Monument Drive Princeton, NJ 08540	Driver License Number Required Contact Date

I understand that I will be required to contact the licensed provider/agency named above by the Required Contact Date listed above, for the purpose of determining if treatment is appropriate and if so, the level of care indicated.

If treatment is appropriate and the level of care is determined, it will be my responsibility to follow the treatment plan developed with my counselor.

I also understand that if I do not cooperate the IDRC is required to refer my case to the sentencing court and that I may be subject to a minimum jail sentence of 2 days, indefinite license suspension and possibly other penalties. I will be eligible for a notification of compliance only after my discharge status has been reported to the IDRC.

Signature of Client	**Date**
Signature of Witness	**Date**

ALC-40
Feb 2008