



<b>Probation Department Access Form for the Impaired Driver System</b>  <b>IMPAIRED DRIVER SYSTEM (IDS)</b>	Individual's Last Name, First Name and MI
	Individual's DMV Client ID (Driver's License Number)
	Probation Department Name and Address

**Instructions**

Maintain a completed copy of this form in the individual's case record.  
Give a completed copy of this form to the individual.

I, the undersigned, hereby **CONSENT** and authorize the above named **Probation Department** to receive information concerning any current and/or past data pertaining to my impaired driving offense including prior conviction(s)/adjudication(s) related to impaired driving and other traffic infractions noted on my driver's abstract and the following data elements:

- **Motorist:** DMV client ID, first two characters of current last name and last name at birth, sex, and birth date.
- **Violation:** violation date, court name, violation, first two characters of current last name, BAC level, indication of chemical test refusal, if any, and an indication of out of state license, if any.
- **Impaired Driving Program:** program name, start and status dates, indication of assessment referral, if any, and IDP enrollment status.
- **Screening:** provider/program name, screening date, indication of assessment referral, if any, and indication of screening tool used.
- **Assessment:** referral source, provider/program name, assessment start and end dates and assessment status.
- **Treatment:** provider/program name(s), admission date(s), discharge date(s), number of sessions, and discharge status.

Such review is for the **PURPOSE** of investigation or supervision.

I, the undersigned, have read the above and authorize the staff of the disclosing entities named to disclose, obtain and share such information as herein specified.

I understand that, unless otherwise specified, this consent will remain in effect and may not be revoked until there has been a formal and effective termination or revocation of my release from confinement and/or parole, probation, interim probation, conditional release, or other proceeding or action pursuant to which I was mandated or otherwise agreed to enter into treatment; or

Duration of consent (if different): \_\_\_\_\_

I understand that disclosure of my personal information by DMV is controlled by the Federal Driver's Privacy Protection Act, 18 USC §2721 and that my signature below constitutes my authorization for DMV to disclose my personal information to the Probation Department indicated above.

I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations 42 CFR Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPPA) 45 CFR Pts. 160 & 164; and that recipients of this information may redisclose it only in connection with their official duties. I further authorize redisclosure by the above-named Probation Department of any aforementioned information to the parties indicated below, if any, for the purposes described below.

(Initial and identify All Applicable)

- Other probation department: \_\_\_\_\_ conducting a court-ordered investigation and/or supervision of the individual.
- Other criminal court: \_\_\_\_\_ for purposes of carrying out its responsibilities for release decision-making purposes, sentencing, violation(s) and/or certificate of relief from disabilities determinations involving the individual.
- District Attorney's Office: \_\_\_\_\_ in furtherance of official duties in connection with the proceeding or action pursuant to which the individual is required or has otherwise agreed to enter treatment.
- Public Defender's Office or Private Defense attorney representing me: \_\_\_\_\_ in connection with representation of the individual in the proceeding or action pursuant to which the individual is required or has otherwise agreed to enter treatment.

Any other redisclosure is forbidden without additional written authorization on my part unless otherwise may be authorized by law

**NOTE:** Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Chemical Dependence Treatment Patient (TRS-1)**.

Name of Individual	Signature of Individual
Date of Signature	Signature of Parent or Guardian of Individual, If Applicable