NEW YORK STATE | Office of Addiction Services and Supports

Consent To Release Of Information Concerning Subject Charged with Impaired Driving **IMPAIRED DRIVER SYSTEM (IDS)**			Individual's Last Name, First Name and MI
			Individual's DMV Client ID (Driver's License Number)
Individual's Case Number or File Reference			Referring Entity's Name and Address
Referring Entity Type			
☐ Court	☐ IDP Provider	☐ Motorist	
☐ DMV	☐ OASAS Approved Provider		

INSTRUCTIONS

1) Give a completed copy of this form to the individual; and

2) Add a completed copy of this form to the individual's case record

I, the undersigned, hereby **CONSENT** and authorize communication between and among the above named **Referring Entity** and the following agencies:

- My OASAS approved provider: _____
  (Enter Name of Provider or N/A if Non-Applicable)
- My Impaired Driver Program (**IDP**): _____
  (Enter Name of Program or N/A if Non-Applicable)
- The New York State Office of Addiction Services and Supports (**OASAS**), NYS Department of Motor Vehicles (**DMV**), NYS Office of Court Administration (**OCA**) and the NYS Division of Criminal Justice Services (**DCJS**) (DCJS will receive non-personally identifying information for research purposes only);

to **DISCLOSE INFORMATION** concerning any current and/or past data pertaining to my impaired driving offense including prior conviction(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, birth date and last four digits of my SSN.
- **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.
- **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, admission date, discharge date, number of sessions and discharge status.
- **IDP**: program name, start and status dates, indication of assessment referral, if any, and IDP enrollment status.

Such disclosure is for the **PURPOSE** of enabling the entities listed above to share the indicated data elements for purposes of data collection, tracking, monitoring activities of providers and programs. The specific data elements disclosed to each entity will be limited to the minimum necessary for that entity to carry out its official duties related to my impaired driving offense in compliance with the NYS Vehicle and Traffic Law (VTL).

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 further understand that, unless otherwise specified, this consent will authorize the use of data to support research and quality assurance measures for OASAS, OCA, DCJS and DMV and will remain in effect for this purpose and cannot be revoked by me for a period of ten (10) years as consistent with the record retention period in NYS VTL §201(1)(i) and the DWI offense level determination clauses of NYS VTL §1192.

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 entities 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 (HIPAA) 45 CFR Pts. 160 & 164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part

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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).

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment and/or determined ineligible for the Impaired Driver Program if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

Print Name of the Individual	Signature of the Individual
Date of Signature	Signature of Parent or Guardian of Individual (If applicable)